First Choice VIP Care Plus (Medicare-Medicaid Plan) *Member Handbook*

January 1, 2024 – December 31, 2024

Your Health and Drug Coverage under the First Choice VIP Care Plus Medicare-Medicaid Plan

Member Handbook Introduction

This handbook tells you about your coverage under First Choice VIP Care Plus through December 31, 2024. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports provide you with the help you need, whether you get services at home or in a nursing home. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

This First Choice VIP Care Plus plan is offered by Select Health of South Carolina, Inc. When this *Member Handbook* says “we,” “us,” or “our,” it means Select Health of South Carolina, Inc. When it says “the plan” or “our plan,” it means First Choice VIP Care Plus.

ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios al Miembro de First Choice VIP Care Plus al **1-888-978-0862 (TTY 711)**, los siete días de la semana, de 8 a.m. a 8 p.m. La llamada es gratuita.

You can get this document for free in other formats, such as large print, braille, or audio. Call **1-888-978-0862 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week. The call is free.

You can make a request to get this document, now and in the future, in Spanish or in another format simply by calling Member Services at **1-888-978-0862 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m. We’ll also ask for your preference during our Welcome Call and later in the year, when you contact the plan. The plan will store your request and continue to send future documents in Spanish or requested format, unless you ask us to cancel or change the request. You can cancel or change your request at any time, simply by calling Member Services. The calls are free.

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Disclaimers

- First Choice VIP Care Plus is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.
- Coverage under First Choice VIP Care Plus is qualifying health coverage called minimum essential coverage. It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about First Choice VIP Care Plus, a health plan that covers all your Medicare and Healthy Connections Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from First Choice VIP Care Plus. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Welcome to First Choice VIP Care Plus

First Choice VIP Care Plus is a Medicare-Medicaid Plan in the Healthy Connections Prime program. A Medicare-Medicaid plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

First Choice VIP Care Plus was approved by the State of South Carolina and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Healthy Connections Prime.

Healthy Connections Prime is a demonstration program jointly run by South Carolina and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

Select Health of South Carolina, Inc. (Select Health) is a managed care organization licensed by the South Carolina Department of Insurance. Headquartered in Charleston, SC, Select Health has served South Carolina for 26 years.

B. Information about Medicare and Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. In South Carolina, Medicaid is called Healthy Connections Medicaid.

Each state decides:

- what counts as income and resources,
- who qualifies,
- which services are covered, **and**

- the cost of those services.

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

Medicare and South Carolina must approve First Choice VIP Care Plus each year. You can get Medicare and Healthy Connections Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the State of South Carolina approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Healthy Connections Medicaid services will not be affected.

C. Advantages of this plan

You will now get all your covered Medicare and Healthy Connections Medicaid services from First Choice VIP Care Plus, including prescription drugs. **You do not pay extra to join this health plan.**

First Choice VIP Care Plus will help make your Medicare and Healthy Connections Medicaid benefits work better together and work better for you. Some of the advantages include:

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

D. First Choice VIP Care Plus's service area

Our service area includes these counties in South Carolina:

Abbeville	Charleston	Fairfield	Lee	Richland
Aiken	Cherokee	Florence	Lexington	Saluda
Allendale	Chester	Georgetown	Marion	Spartanburg
Anderson	Chesterfield	Greenville	Marlboro	Sumter
Bamberg	Clarendon	Greenwood	McCormick	Union
Barnwell	Colleton	Hampton	Newberry	Williamsburg
Beaufort	Dillon	Jasper	Oconee	
Berkeley	Dorchester	Kershaw	Orangeburg	
Calhoun	Edgefield	Laurens	Pickens	

Only people who live in our service area can get First Choice VIP Care Plus.

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8, Section J, page 11, for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area; (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it), **and**
- are age 65 or older at the time of enrollment; **and**
- have Medicare Parts A, B, and D; **and**
- are eligible for full Healthy Connections Medicaid benefits; **and**
- are a United States citizen or are lawfully present in the United States.

Even if you meet the above criteria, you are not eligible for our plan if you:

- are part of the Healthy Connections Medicaid spend-down population; **or**
- have Comprehensive Third Party Insurance; **or**
- live in an Intermediate Care Facility for people with Intellectual Disabilities (ICF/IID) or Nursing Facility at the time of eligibility determination; **or**
- are in a hospice program or are getting End-Stage Renal Disease (ESRD) services at the time of eligibility determination; **or**

- are participating in a community long-term care waiver program other than the Community Choices Waiver, HIV/AIDS Waiver, or Mechanical Ventilation Waiver.

You may choose to **either enroll or remain in First Choice VIP Care Plus** if you:

- are currently enrolled in a Medicare Advantage plan or in Program of All-inclusive Care for the Elderly (PACE). Enrolling in Healthy Connections Prime will automatically disenroll you from your existing program and any Medicare Part D plan; **or**
- transition from a Nursing Facility or ICF/IID into the community; **or**
- are already enrolled in this plan but later enter a Nursing Facility**; or**
- are enrolled in this plan but enter a hospice program or become eligible for ESRD services.

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

When you first join the plan, you will get an initial health screen within the first 30 days to collect information about your medical and social history and needs.

You will also get a comprehensive assessment within the first 60 or 90 days depending on your health needs. The comprehensive assessment will take a deeper look at your medical needs, social needs, and capabilities. We will get information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified and trained health professionals, such as nurses, social workers, and care coordinators.

We may combine your initial health screen and comprehensive assessment into one assessment that is done within the first 60 days. Generally, people who are enrolled in certain Healthy Connections Medicaid waiver programs will get the combined initial health screen and comprehensive assessment.

If your comprehensive assessment shows you have very high health needs, you may be required to complete a Long Term Care Assessment with a registered nurse. The Long Term Care Assessment determines whether you need additional care in a nursing facility or through a community-based waiver.

If First Choice VIP Care Plus is new for you, you can keep using the doctors you use now and keep your current service authorizations for 180 days after you first enroll. During this time period, you will continue to have access to the same medically necessary items, services, and prescription drugs as you do today. You will also still have access to your medical, mental health and Long Term Services and Supports (LTSS) providers.

Many of your doctors and other providers are in our network already, but if they are not, after 180 days in our plan, you will need to use doctors and other providers in our network. We may help you transition to a network provider in less than 180 days once we have completed your comprehensive assessment, developed a transition plan, and only if you agree. A network provider is a provider who works with the health plan. Refer to Chapter 3, Section D, page 6 for more information on getting care.

G. Your care plan

Your care plan is the plan for what health services you will get and how you will get them.

After your comprehensive assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make your care plan.

Every year, your care team will work with you to update your care plan if the health services you need and want change.

H. First Choice VIP Care Plus monthly plan premium

First Choice VIP Care Plus does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal or challenge our action. For information about how to appeal, refer to Chapter 9 Section D, page 6, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the number at the bottom of the page. You can also refer to the *Member Handbook* at www.firstchoicevipcareplus.com or download it from this website.

The contract is in effect for the months you are enrolled in First Choice VIP Care Plus between January 1, 2024, and December 31, 2024.

J. Other important information you will get from us

You should have already gotten a First Choice VIP Plus Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*.

J1. Your First Choice VIP Care Plus Member ID Card

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

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

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Healthy Connections Medicaid card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your First Choice VIP Care Plus Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A, page 2, to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the First Choice VIP Care Plus network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (refer to Chapter 3, Section B, page 3).

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the number at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* on our website listed at the bottom of the page or download it from this website.

This Directory lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support providers that you may see as a First Choice VIP Care Plus member. We also list the pharmacies that you may use to get your prescription drugs.

Definition of network providers

- First Choice VIP Care Plus's network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - home health agencies, durable medical equipment suppliers, waiver services providers, long-term services and supports providers, and others who provide goods and services that you get through Medicare or Healthy Connections Medicaid.

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

Definition of network pharmacies

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

Call Member Services at the number at the bottom of the page for more information. Both Member Services and First Choice VIP Care Plus's website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by First Choice VIP Care Plus.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5, Section C, page 11 for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit our website using the information at the bottom of the page or call Member Services at the number at the bottom of the page.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6, Section A, page 4 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

K. How to keep your membership record up to date

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

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

Let us know the following:

- changes to your name, your address, or your phone number
- changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- any liability claims, such as claims from an automobile accident

- admission to a nursing facility or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- changes in who your caregiver (or anyone responsible for you) is
- you are part of or become part of 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 information changes, please let us know by calling Member Services at the number at the bottom of the page.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8, Section C, page 5.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about First Choice VIP Care Plus and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and other people who can help you. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. How to contact First Choice VIP Care Plus Member Services

CALL	**1-888-978-0862**. This call is free. Seven days a week, 8 a.m. to 8 p.m. After regular business hours, weekends,and holidays, the interactive voice response system will allow you to leave a message.. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. Seven days a week, 8 a.m. to 8 p.m. After regular business hours, weekends,and holidays, the interactive voice response system will allow you to leave a message.
WRITE	First Choice VIP Care Plus P.O. BOX 7107 London, KY 40742-7107
WEBSITE	www.firstchoicevipcareplus.com

A1. When to contact Member Services

- questions about the plan
- questions about claims, billing or Member ID Cards
- coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - your benefits and covered services, **or**
        - the amount we will pay for your health services.
    - Call us if you have questions about a coverage decision about health care.
    - To learn more about coverage decisions, refer to Chapter 9, Section D, page 6.
- appeals about your health care
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
    - To learn more about making an appeal, refer to Chapter 9, Section D2, page 7.

- complaints about your health care
    - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint to us or to the Quality Improvement Organization about the quality of the care you received (refer to Section E below, page 9).
    - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above titled “Appeals about your health care”).
    - You can send a complaint about First Choice VIP Care Plus right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
    - To learn more about making a complaint about your health care, refer to Chapter 9, Section C, page 5.
- coverage decisions about your drugs
    - A coverage decision about your drugs is a decision about:
        - your benefits and covered drugs, **or**
        - the amount we will pay for your drugs.
    - This applies to your Medicare prescription drugs, Healthy Connections Medicaid prescription drugs, and Healthy Connections Medicaid over-the-counter drugs.
    - For more on coverage decisions about your prescription drugs, refer to Chapter 9, Section D, page 6.
- appeals about your drugs
    - An appeal is a formal way to ask us to change a coverage decision.

    Healthy Connections Medicaid prescription and over-the-counter drugs are included in Tier 3 of the Drug List. Medicare Part D prescription drugs are included in Tiers 1 and 2 of the Drug List. If you would like to file an appeal for Healthy Connections Medicaid drugs, Tier 3 over-the-counter drugs, (OTC) or Part D drugs, call Member Services at the number at the bottom of the page.

    - For more on making an appeal about your prescription drugs, refer to Chapter 9, Section F, page 23.

- complaints about your drugs
    - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
    - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
    - You can send a complaint about First Choice VIP Care Plus right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
    - For more on making a complaint about your prescription drugs, refer to Chapter 9 Section F, page 23.
- payment for health care or drugs you already paid for
    - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7, Section A, page 2.
    - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9, Section D, page 6 for more on appeals.

B. How to contact your care coordinator

You are assigned your own personal care coordinator who is your “go-to” person for First Choice VIP Care Plus. A care coordinator is a compassionate health professional who will help you get care and services that affect your health and wellbeing. They will complete detailed assessments with you that include your medical history, medication list, vaccinations, and health screenings, among other things. Your care coordinator will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your care coordinator and set goals for healthy living. Whenever you have a question or a problem about your health or services or care you are getting from us, you can call your care coordinator.

Our goal at First Choice VIP Care Plus is to meet your needs in a way that works for you. This is why we call our program “person-centered.” The person-centered planning process is when you work with your care coordinator to create a care plan that is about **your** goals, choices, and abilities. When you create your care plan, you are welcome to involve people you feel are key to your success, such as family members, friends, or legal representatives.

CALL	**1-888-978-0862.** This call is free. Monday through Friday, 8 a.m. to 5 p.m. After regular business hours, the interactive voice response system will allow you to leave a message or your care coordinator. We have free interpreter services for people who do not speak English.
TTY	**711.** This call is free. Monday through Friday, 8 a.m. to 5 p.m.
WRITE	First Choice VIP Care Plus 4389 Belle Oaks Drive Suite 400 Charleston, SC 29405
WEBSITE	www.firstchoicevipcareplus.com

B1. When to contact your care coordinator

- questions about your health care

- after any hospital stay
- if your health status changes
- help with scheduling appointments
- questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)

LTSS are available to members who are on certain waiver programs operated by the Community Long Term Care (CLTC) division of the Healthy Connections Medicaid. Those waivers are:

- Community Choices waiver
- HIV/AIDS waiver
- Mechanical Ventilator Dependent waiver

If you think you need LTSS, you can talk to your care coordinator about how to access them and whether you can join one of these waivers. If you qualify for one of the CLTC waivers, you may be eligible to receive ***certain*** long term services and supports through First Choice VIP Care Plus to help you until waiver services are available. These services include personal care and companion services.

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

- personal care attendant
- home health care
- adult day care
- companion services
- speech therapy
- medical social services

C. How to contact the Nurse Advice Call Line

The 24/7 Nurse Call Line is a free service that provides access to a registered nurse who can answer your questions about health concerns. The Nurse Advice Call Line is staffed by registered nurses and is available 24 hours a day, seven days a week. If you are unable to reach your primary care provider (PCP), and believe that you are in need of urgent care, you may call the 24/7 Nurse Call Line. A nurse will help you decide if you need to go to your PCP's office, an urgent care center near you, or the Emergency Room (ER). The phone number for the Nurse Advice Call Line is below.

CALL	1-855-843-1147. This call is free. 24 hours a day, seven days a week. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. 24 hours a day, seven days a week

C1. When to contact the Nurse Advice Call Line

- questions about your health care

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

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. I-CARE is not connected with any insurance company or health plan.

Information about the I-CARE program is available through the Department on Aging.

CALL	1-800-868-9095 This call is free. Office hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.
TTY	711.This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

WRITE	Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201
EMAIL	askus@aging.sc.gov
WEBSITE	www.aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud

D1. When to contact I-CARE

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

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

The QIO is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. In South Carolina, the QIO is a company called KEPRO. KEPRO is not connected with our plan.

CALL	1-888-317-0751. This call is free. KEPRO team members are available 9:00 a.m. to 5:00 p.m. Monday through Friday and from 11:00 a.m. to 3:00 p.m. on Saturdays, Sundays, and holidays. You can also leave a message 24 hours a day, 7 days a week. Translation services are available for members and caregivers who do not speak English.
TTY	1-855-843-4776 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it
WRITE	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	www.keproqio.com/

E1. When to contact KEPRO

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

F. How to contact Medicare

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

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

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

G. How to contact Healthy Connections Medicaid

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

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

CALL	1-888-549-0820. This call is free. This number is available Monday through Friday from 8:00 a.m. to 6:00 p.m.
TTY	1-888-842-3620. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202
WEBSITE	www.scdhhs.gov

H. How to contact the Healthy Connections Prime Advocate

The Healthy Connections Prime Advocate is the ombudsman for people enrolled in Healthy Connections Prime. An ombudsman is an office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Healthy Connections Prime Advocate also helps people enrolled in Healthy Connections Prime with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-844-477-4632 Office hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
FAX	1-803-734-4534
WRITE	Healthy Connections Prime Advocate Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201
EMAIL	primeadvocate@aging.sc.gov
WEBSITE	www.healthyconnectionsprimeadvocate.com

I. How to contact the South Carolina Long Term Care Ombudsman

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

Information about the South Carolina Long Term Care Ombudsman is available through the Department on Aging.

CALL	1-800-868-9095. This call is free. Office hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.
WRITE	Long Term Care Ombudsman Department on Aging 1301 Gervais St., Suite 350 Columbia, SC 29201
EMAIL	ltcombudsman@aging.sc.gov
WEBSITE	www.aging.sc.gov

J. Other resources

The 988 Suicide & Crisis Lifeline

CALL	1-800-273-8255 Spanish speaking members call: 1-888-628-9454 Available 24 hours a day, seven days per week
TTY	711 Available 24 hours a day, seven days per week
WEBSITE	https://988lifeline.org

How to report fraud and abuse

If you suspect that fraud, waste or abuse is occurring, please let us know.

CALL	1-866-833-9718, Available seven days a week, 24 hours
TTY	711 Available 24 hours a day, seven days per week
WRITE	Special Investigations Unit P.O. Box 7319 London KY 40742
EMAIL	FWA Secure Contact Form on website and FraudTip@amerihealthcaritasdc.com
WEBSITE	www.firstchoicevipcareplus.com

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

Introduction

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

Table of Contents

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

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and LTSS are listed in the Benefits Chart in Chapter 4, Section D, page 5.

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

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

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

First Choice VIP Care Plus covers all services covered by Medicare and Healthy Connections Medicaid. This includes behavioral health and LTSS.

First Choice VIP Care Plus will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D, page 5 of this handbook).
- The care must be **medically necessary**. Medically necessary means that the services are reasonable and necessary:
    - For the diagnosis or treatment of your illness or injury; **or**
    - To improve the functioning of a malformed body member; **or**
    - Otherwise medically necessary under Medicare law.
- In accordance with Healthy Connections Medicaid law and regulation, services must be:
    - Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity;

- Provided at an appropriate facility at the appropriate level of care for the treatment of your medical condition; **and**
- Provided in accordance with generally accepted standards of medical practice.

- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
  - In most cases, our plan must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, First Choice VIP Care Plus may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. To learn more about referrals, refer to page 7.
  - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 7.
  - To learn more about choosing a PCP, refer to page 5.
- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to Section I, page 12.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. Authorization should be obtained from the plan prior to seeking care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to use an out-of-network provider, refer to Section D, page 6.
  - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility. The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the

service area from an out-of-network provider the cost sharing for the dialysis may be higher.

- When you first join the plan, you can continue using the providers you use now for 180 days or until we have completed your comprehensive assessment and created a transition plan that you agree with. If you need to continue using your out-of-network providers after your first 180 days in our plan, we will only cover that care if the provider enters a single case agreement with us. If you are getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact Member Services at **1-888-978-0862 (TTY 711)**.

C. Information about your care coordinator

C1. What a care coordinator is

Your First Choice VIP Care Plus care coordinator is your "go-to" person for First Choice VIP Care Plus. A care coordinator is a compassionate health professional trained to help you manage your care. They will complete detailed assessments with you that include your medical history, medication list, vaccinations, and health screenings, among other things. Your care coordinator will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your care coordinator and set goals for healthy living.

C2. How you can contact your care coordinator

To contact your care coordinator, call First Choice VIP Care Plus Member Services, at the phone number at the bottom of the page.

C3. How you can change your care coordinator

To change your care coordinator, call First Choice VIP Care Plus Member Services, at the phone number at the bottom of the page.

D. Care from primary care providers, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

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

A Primary Care Provider (PCP) is a doctor who meets Medicare and State requirements and is trained to give you basic medical care.

There are different kinds of doctors who can act as PCPs. Generally, PCPs specialize in family practice, general practice, or internal medicine. You may be able to have a specialist act as your PCP. A specialist can act as your PCP as long as they perform PCP functions. This will allow us to assign them to you and pay your claims as a PCP. If you would like your specialist to act as your PCP, contact Member Services to make the request.

The role of a PCP in:

- coordinating covered services

  Your PCP will coordinate covered services you get as a member of our plan. Your PCP is part of your care team. Your care team works together to make sure your care is coordinated. This means that your PCP should know all medicines you take to reduce the risk of any negative effects. Your PCP will get your permission before sharing your medical information with other providers.

- making decisions about or obtaining prior authorization (PA), if applicable

  For some services, your PCP may need to get approval in advance from First Choice VIP Care Plus (this is called "prior authorization"). In these cases, your PCP will be asked to provide information on your medical condition and the proposed treatment plan so that First Choice VIP Care Plus can determine if the service is medically necessary.

  When a clinic can be your primary care provider (RHC/FQHC)

  You can choose a provider at a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) that is in our network to be your primary care provider.

Your choice of PCP

You should choose a Primary Care Physician (PCP) you are comfortable seeing and using to manage all of your health care needs. You can change PCPs at any time. If you would like to see the doctors available as a PCP, you should review our print or online provider directory, or call Member Services to confirm that your doctor is part of our network. Contact Member Services, at the phone number at the bottom of the page to choose a PCP.

If you do not choose a PCP within the first 90 days of enrollment, and First Choice VIP Care Plus has made reasonable, unsuccessful attempts to help you (by phone or by mail) in selecting a PCP, then First Choice VIP Care Plus will assign a PCP to you, then notify you and the PCP of the assignment. This PCP assignment shall not negatively impact any transition rights that you may have.

Option to change 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. We can help you find a new PCP if the one you have now leaves our network.

Once you select a new PCP, it will take five business days for the change to go into effect. You will have to contact Member Services to change your PCP. Please call Member Services at the phone number at the bottom of the page. The call is free.

Services you can get without first getting approval from your PCP

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

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or you need immediate care during the weekend).

  NOTE: Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations as long as you get them from a network provider.

- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to get services from Indian health providers, you may use these providers without a referral.
- Medicare-covered preventive screenings
- Kidney disease education services
- Diabetes self-management training

D2. Care from specialists and other network providers

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

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

When you need care from specialty providers, including home health and behavioral health services, you should coordinate care with your primary care physician (PCP). Your PCP will assist you in selecting an appropriate in-network provider and will complete any necessary requirements for you. If you have any concerns or questions you may contact your care coordinator for assistance. For some types of services, your PCP or specialist may need to get approval from our plan before getting a specific service or drug. This is called "prior authorization". In these cases, your PCP or specialist will be asked to provide information on your medical condition and the proposed treatment plan so that the plan's Utilization Management department can determine if the service is medically necessary. Please refer to the benefits chart in Chapter 4, Section D for information about which services require prior authorization.

Selection of a PCP does not limit you to specific specialists or hospitals. We do not have subnetworks or referral circles. You should see specialists that are in-network.

D3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask for, and we will work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision. Refer to Chapter 9 Section E, page 10 for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please call Member Services at the phone number at the bottom of the page. The call is free.

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

In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section H in this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In order to get care from an out-of-network provider, prior authorization is required. Your PCP or specialist will be asked to provide information on your medical condition and the proposed treatment plan so that the plan can determine if the service is medically necessary. In this situation, we will cover these services as if you got the care from a network provider.

The out-of-network provider is responsible for obtaining prior authorization from the plan. To obtain prior authorization, the out-of-network provider needs to contact the plan and will be asked to provide information on your medical condition and the proposed treatment plan so that the Plan can determine if the service is medically necessary.

If you require specialty care not available from a network provider, First Choice VIP Care Plus will make arrangements to have the specialty services provided by an out-of-network provider. In such event, the plan will negotiate a single case agreement with an out-of-network provider until a qualified network provider is available. An out-of-network provider does not have to accept a single case agreement. First Choice VIP Care Plus cannot force an out-of-network provider to bill the plan instead of you.

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

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

E. How to get behavioral health services

There are several ways to find a behavioral health provider. You can call Member Services at the number at the bottom of the page. The call is free.

You can also contact your care coordinator or search for a behavioral health provider in *the Provider and Pharmacy Directory*. The *Provider and Pharmacy Directory* can also be found online at www.firstchoicevipcareplus.com.

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

Long-term services and supports (LTSS) help meet your daily needs for assistance and help improve the quality of your life. LTSS can help you with everyday tasks like taking a bath, getting dressed, and making food. Most of these services are provided in your home or in your community, but they could also be provided in a nursing home or hospital.

LTSS are available to members who are on certain waiver programs operated by the Community Long Term Care (CLTC) division of Healthy Connections Medicaid. Those waivers are:

- Community Choices waiver
- HIV/AIDS waiver
- Mechanical Ventilator Dependent waiver

Members on different waivers can get different kinds and amounts of LTSS. If you think you need LTSS, you can talk to your care coordinator about how to access them and whether you can join one of these waivers. Your care coordinator can give you information about how to apply for an appropriate waiver and all of the resources available to you under the plan.

Refer to the *Provider and Pharmacy Directory* for more information about these programs.

If you qualify for one of the CLTC waivers, you may be eligible to receive certain LTSS through First Choice VIP Care Plus to help you until waiver services are available. These services include personal care and companion services.

G. How to get self-directed care

G1. What self-directed care is

Self-Directed Personal Assistance Services are personal assistance services like those described above (help with bathing, dressing, meal preparation, light housekeeping) that are directed by the member or member's designated representative. This approach to receiving personal assistance services allows the member or member's representative to provide specific direction to the provider about their needs and preferences. This approach ensures that the service will meet the member's needs.

G2. Who can get self-directed care

Self-Directed Personal Assistance Services are available to all plan members who are enrolled in one of the three waivers mentioned above in Section F. Your care coordinator can assist you in using the self-directed approach if you are interested.

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

If you need help finding or employing personal care providers, please call Member Services at the number at the bottom of the page.

H. How to get transportation services

Non-Emergency Transportation (NEMT) Services are provided through Healthy Connections Medicaid as a fee-for-service Medicaid benefit. First Choice VIP Care Plus will coordinate your NEMT service. Call Member Services at the number at the bottom of the page. The call is free. You can also contact your care coordinator who can help you coordinate your Healthy Connections Medicaid NEMT benefit.

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

I1. Care when you have a medical emergency

Definition of a medical emergency

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

- serious risk to your health; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use 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 provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- **As soon as possible, make sure that you tell our plan 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. However, you will not have to pay for emergency services because of a delay in telling us. Please call Member Services at the phone number at the bottom of the page.

Covered services in a medical emergency

Medicare does not provide coverage for emergency medical care outside the United States and its territories. You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, see the Benefits Chart in Chapter 4, Section D, page 5.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What to do if you have a behavioral health emergency

- **Get help as fast as possible**. Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP.
- As soon as possible, make sure that you tell our plan about your emergency. We need to follow up on your emergency care. You or your care coordinator should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Please call Member Services at the phone number at the bottom of the page. The call is free.

Getting emergency care if it wasn't an emergency after all

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

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

- you use a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

I2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

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

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

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

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

If you need urgent care, but you are not sure if it is an emergency, call your PCP first. If you cannot reach your PCP, call the 24/7 Nurse Call Line at **1-855-843-1147 (TTY 711)**. Your PCP or the nurse will help you decide if you need to go to the PCP's office, an urgent care center near you, or the Emergency Room.

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

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

Our plan does not cover urgently needed care or any other care that you get outside the United States.

I3. Care during a disaster

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

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

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at the in-network cost-sharing rate. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

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

Do not pay directly for services that Healthy Connections Medicaid covers.

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

If you pay the provider, we can't pay you back, but the provider will. Member Services or the Healthy Connections Prime Advocate can help you contact the provider's office. Refer to the bottom of the page and Chapter 2, Section H, page 12 for their phone numbers.

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

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7, Section A, page 2 to learn what to do**.**

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

First Choice VIP Care Plus covers all services:

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

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

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

Chapter 9, Section E, page 10 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

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

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

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

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

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

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

However, we encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will be in a clinical trial.

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

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

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

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

K3. Learning more about clinical research studies

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

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

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

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

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.
- Medicare Inpatient Hospital coverage limits apply. See Inpatient Hospital Care in the Benefits Chart in Chapter 4 Section D, page 5.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of First Choice VIP Care Plus, our plan will rent most DME items for you for a maximum of 10 months. In some cases, it may be 13 months. At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. Our plan may pay for maintenance fees. Call Member Services to find out more.

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

If you are renting DME, there are extra things for you to consider if you decide to switch to Original Medicare or a Medicare Advantage plan.

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

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents

- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services First Choice VIP Care Plus covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services and your out-of-pocket costs

This chapter tells you what services First Choice VIP Care Plus pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section B, page 9. This chapter also explains limits on some services.

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

If you need help understanding what services are covered, call your care coordinator and/or Member Services at the number at the bottom of the page.

A1. During public health emergencies

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.

Visit our website: www.firstchoicevipcareplus.com for information on how to obtain needed care during a disaster.

Generally, 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. When it is declared a federal disaster or state of emergency by the government, we allow access to out-of-network pharmacies to prevent an interruption in service.

For more information on coverage and reimbursement, please call Member Services at **1-888-978-0862 (TTY 711)**. Coverage and reimbursement may change or stop based on the status of the public health emergency.

B. Rules against providers charging you for services

We do not allow First Choice VIP Care Plus providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to Chapter 7, Section A, page 2 or call Member Services.

C. Our plan's Benefits Chart

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

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

- Your Medicare and Healthy Connections Medicaid covered services must be provided according to the rules set by Medicare and Healthy Connections Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means services that are reasonable and necessary for the diagnosis or treatment of your illness or injury, to improve the functioning of a malformed body member, or otherwise medically necessary under Medicare law. In accordance with Healthy Connections Medicaid law and regulation, services must be to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. The services must also be provided in an appropriate facility for your medical condition and follow generally accepted standards of medical care.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, page 6 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3, Section D, page 6 has more information about getting a referral and explains when you do not need a referral.
- When you first join the plan, you can continue using the providers you use now for 180 days or until we have completed your comprehensive assessment and created a transition plan that you agree with. If you need to continue using your out-of-network providers after your first 180 days in our plan, we will only cover that care if the provider enters a single case agreement with us. A single case agreement is an exception to treat the provider as an in-network provider. If you are getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact Member Services at **1-888-978-0862 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m.

- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Covered services that need PA are marked in the Benefits Chart by an asterisk (*).
- All preventive services are free. You will find this apple  next to preventive services in the Benefits Chart.

D. The Benefits Chart

General services that our plan pays for		What you must pay
🍎	**Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Acupuncture for chronic low back pain The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); **and** • not associated with surgery. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. **Prior Authorization is required.*	$0*

General services that our plan pays for		What you must pay
	Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting. You can also get rehabilitative and recovery services focused on coping skills which will help you manage your symptoms and behaviors. These services may be in an individual or group setting.	$0
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. *Prior Authorization **is not** required for emergency ambulance services.* *Prior Authorization **is not** required for ambulance services between acute and sub-acute facilities.* **Prior Authorization **is** required for all other ambulance services.*	$0*

General services that our plan pays for		What you must pay
	Annual wellness visit If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.	$0
	Bathroom Safety Devices Bathroom safety devices are a designated HCBS waiver benefit. First Choice VIP Care Plus can provide bathroom safety devices to members who are not currently enrolled in a waiver but demonstrate the need. Care Coordinators must authorize these services for members who meet the criteria. **Prior Authorization required.*	$0*

General services that our plan pays for		What you must pay
	Behavioral health services Rehabilitative Behavioral Health Services (RBHS) Services include: Assessment services, Service Plan Development, Therapy services, Substance Abuse Counseling, Crisis Management, Medication Management, and Community Support Services. Community Support Services consist of Psychosocial Rehabilitative Services (PRS), Behavior Modification, Family Support, Peer Support Services, Psych evaluations, psychotherapy therapy services, additional psychotherapy services, cognitive capability assessments, injections, Evaluation and Management (E&M) – New Patient, Evaluation and Management (E&M) – Established Patient, Consultations, Interdisciplinary Conference, Counseling Services, Risk Factor and Behavioral Change Modifications, Laboratory Services, Alcohol and Drug Abuse Treatment Services, Injectables, Community and Integration Services (CIS), Temporary national coding, and Registered Nurse Services (RN). Rehabilitative Services are provided to or directed exclusively toward the treatment of the beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.	$0
	**Bone mass measurement** The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will pay for the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0

General services that our plan pays for		What you must pay
	Breast cancer screening (mammograms) The plan will pay for the following services: • one screening mammogram every 12 months for women age 40 and older • clinical breast exams once every 24 months	$0
	Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. **Prior Authorization required.*	$0*
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, **or** • give you tips to make sure you are eating well.	$0
	Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0

General services that our plan pays for		What you must pay
	**Cervical and vaginal cancer screening** The plan will pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months	$0
	Chiropractic services The plan will pay for the following services: • adjustments of the spine to correct alignment • other chiropractic services that are medically necessary. ○ For other chiropractic services to be covered, you must have a significant health problem in the form of a neuromuscular condition. Chiropractic services for diseases not directly related to your spine, such as rheumatoid arthritis, muscular dystrophy, multiple sclerosis (MS), pneumonia, and emphysema, are not covered.	$0

General services that our plan pays for	What you must pay
Colorectal cancer screening The plan will pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	$0

General services that our plan pays for		What you must pay
	Companion Services Companion services are offered as a supplemental benefit to members who are not enrolled in a waiver, but demonstrate the need for these services, for a temporary period of time. These benefits are provided to prevent or delay hospital or long-term nursing home placement. Care Coordinators must authorize these services for members who meet the criteria. **Prior Authorization required.*	$0*
🍎	**Counseling to stop smoking or tobacco use** If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	$0

General services that our plan pays for		What you must pay
	Dental services First Choice VIP Care Plus will pay for the following services: • emergency medical procedures performed by oral surgeons. • dental procedures related to the following: • organ transplants • oncology • radiation of the head and/or neck for cancer treatment • chemotherapy for cancer treatment • total joint replacement • heart valve replacement • trauma treatment performed in a hospital or ambulatory surgical center We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. **Prior Authorization required.*	$0*
	Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.	$0

General services that our plan pays for		What you must pay
	Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months	$0

General services that our plan pays for	What you must pay

Diabetic self-management training, services, and supplies
 	
The plan will pay for the following services for all people who have diabetes (whether they use insulin or not):
• Supplies to monitor your blood glucose, including the following:
  ○ a blood glucose monitor
  ○ blood glucose test strips
  ○ lancet devices and lancets
  ○ glucose-control solutions for checking the accuracy of test strips and monitors
• For people with diabetes who have severe diabetic foot disease, the plan will pay for the following:
  ○ one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or**
  ○ one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)
  The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.
• The plan will pay for training to help you manage your diabetes, in some cases.
  ○ You are eligible for Diabetes Management Services if your provider determines this will help you.
  ○ You are limited to 10 hours of diabetes education in your lifetime.
• Continuous Glucose Monitors (CGMs) and their accompanying supplies
 	
**Prior Authorization is required for non-preferred brands of diabetic supplies.*
 	
**Prior Authorization is required for preferred and non-preferred brands of Continuous Glucose Monitors and their accompanying supplies.*
	$0*

General services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (For a definition of "Durable medical equipment (DME)," refer to Chapter 12 of this handbook.) The following items are covered: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps • speech generating devices • oxygen equipment and supplies • nebulizers • walkers Other items may be covered. We will pay for all medically necessary DME that Medicare and Healthy Connections Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. White canes for the blind are not covered. As a member of First Choice VIP Care Plus, our plan will rent most DME items for you for a maximum of 10 months. In some cases, it may be 13 months. At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. Our plan may pay for maintenance fees. **This benefit is continued on the next page**	The copay is $0 for durable medical equipment covered by Medicare. The copay is $3.40 for durable medical equipment covered only by Healthy Connections Medicaid.*

General services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (continued) **Prior Authorization is required for all Medicare and Healthy Connection Medicaid DME items.* *However, case managers for CLTC waiver may authorize durable medical equipment for waiver participants.*	
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part Emergency services are only covered when you get them within the U.S.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.

General services that our plan pays for		What you must pay
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider-to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy, or family planning office. The plan will pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods • family planning supplies with prescription (condoms) • counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • treatment for sexually transmitted infections (STIs) • voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) The plan will also pay for some other family planning services. However, you must use a provider in the plan's network for the following services: • treatment for medical conditions of infertility • treatment for AIDS and other HIV-related conditions • genetic testing	$0
	Fitness benefit Silver Sneakers ® is a free fitness benefit that includes access to participating Silver Sneakers fitness facilities, online wellness resources, and classes.	$0

General services that our plan pays for	What you must pay
Health and wellness education programs The plan has a range of health and wellness education programs activities for members, their family members, and other informal caregivers. Some examples of topics that may be covered are: • self-management for chronic conditions • quitting smoking • preventing falls • caregiver support • nutrition • alcohol and drug abuse • managing your medications • fitness • disease planning • preparing for emergencies Preventive Services for Primary Care Enhancement (PSPCE) helps prevent disease, disability, and other health conditions. These services may also slow down the disease, help members live longer, and promote physical and mental health. PSPCE encourages members to see their primary care providers to achieve positive health outcomes. Rehabilitative Services for Primary Care Enhancement (RSPCE) help reduce physical or mental disability and get members functioning the best they can. Needs Assessment and Intervention Case Plan is a screening to see if a member is a good fit for a program, project, or treatment protocol.	$0

General services that our plan pays for	What you must pay
Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. **Routine hearing services - You must see a TruHearing provider to use this benefit.** If you have a cochlear implant or a surgically implanted hearing device, the plan pays for replacement parts. • $0 for up to one routine hearing exam every year • $1,500 allowance toward the cost of a non-implantable hearing aid[s] every three years for both ears combined Hearing Aid purchase includes: • $0 for up to 3 fittings for a hearing aid every three years: During the first 12 months after a TruHearing-brand hearing aid purchase, the plan will cover a limited number of follow-up visits for fitting and adjustments. The benefit does not apply to any other hearing aid brands. • $0 for 80 batteries per hearing aid for non-rechargeable models • 60-day trial period. 60-day trial periods allow the member to try the hearing aid(s) for the allotted amount of time. If, for any reason, the member wants to return or exchange the hearing aid(s) during that time, they can do so at no additional charge. If they exchange the hearing aid(s) for a different style, the trial period would start over when they receive the new aid(s). The benefit does **not** include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries **This benefit is continued on the next page**	$0

General services that our plan pays for		What you must pay
	Hearing services (continued) • Hearing aids that are not in the TruHearing catalog • Costs associated with loss and damage warranty claims • Costs associated with excluded items are the responsibility of the member and are not covered by the plan.	
	**HIV screening** The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. Members who have HIV or AIDS can get extra services by joining a Community Long Term Care (CLTC) waiver program. Refer to Section E, page 56, for more information about services for members who qualify.	$0

General services that our plan pays for		What you must pay
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies (including, but not limited to, incontinence supplies) Personal Care Services: Home health aide services are of a personal care nature, are medically oriented, and include assistance in activities of daily living and retaining self-help skills, for example, helping with bathing, helping with prescribed exercises, or assisting in ambulation. These services must be prescribed by a physician in accordance with a plan of care and supervised by a registered nurse. **Prior Authorization required.* *You must talk to your provider and get a referral for Personal Care Services.*	The copay is $0 for home health care services covered by Medicare. The copay is $3.30 personal care services covered only by Healthy Connections Medicaid.*.*

General services that our plan pays for		What you must pay
	Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. **Prior authorization required.*	$0*

General services that our plan pays for		What you must pay
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • drugs to treat symptoms and pain • short-term respite care • home care **Hospice services and services covered by Medicare Part A or B are billed to Medicare:** • Refer to Section G of this chapter for more information. **For services covered by First Choice VIP Care Plus but not covered by Medicare Part A or B:** • First Choice VIP Care Plus will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by First Choice VIP Care Plus's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F, page 17. **This benefit is continued on the next page**	$0 When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. First Choice VIP Care Plus does not pay for your services.

General services that our plan pays for		What you must pay
	Hospice care (continued) **Note**: If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Call First Choice VIP Care Plus, at the number at the bottom of the page, to contact your care coordinator. • Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	
	Immunizations The plan will pay for the following services: • pneumonia vaccine • flu shots, once each flu season, in the fall and winter, with additional flu shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will pay for other vaccines that meet the Healthy Connections Medicaid or Medicare Part D coverage rules. Read Chapter 6, Section D, page 8, to learn more.	$0

General services that our plan pays for		What you must pay
	Incontinence supplies The plan will pay for incontinence supplies if your doctor believes you need them. The quantities and frequencies of supplies are determined by your level of incontinence. Limited to 1 case of incontinence supplies per month. First Choice VIP Care Plus may authorize incontinence supplies above the maximum amount based on medical necessity. Incontinence Supplies: Authorization of diapers/pull-ups and under pads for adults (age 21 and older) must be based on frequency. To learn how we classify occasional, frequent, and total incontinence, contact your care coordinator *Prior Authorization required.	$0*

General services that our plan pays for		What you must pay
	Infusion therapy The plan covers infusion pumps (and some medicines used in infusion pumps) that a doctor prescribes for use in your home. If you don't want to get infusion therapy in a doctor's office or hospital, you can use an infusion center. Refer to the *Provider and Pharmacy Directory* for a list of infusion centers. You can get the following services at an infusion center: • chemotherapy • hydration • intravenous immunoglobulin (IVIG) • blood and blood products • antibiotics • intrathecal/lumbar puncture • inhalation • therapeutic phlebotomy A doctor will be on-site at the infusion center in case there are medical emergencies. **Prior Authorization required.*	$0*
	In-home safety assessment An in-home safety assessment is included in the comprehensive assessment.	$0

General services that our plan pays for		What you must pay
	Inpatient hospital care The plan will pay for the following services, and maybe other services not listed here: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • blood, including storage and administration • physician services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	$0* You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

General services that our plan pays for		What you must pay
	Inpatient hospital care (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If First Choice VIP Care Plus provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. We do not pay for extra charges for a private hospital room (unless medically necessary), private nurse, or personal convenience items (e.g., telephone and television). **Prior Authorization required.*	

General services that our plan pays for		What you must pay
	Inpatient services in a psychiatric hospital • The plan will pay for mental health care services that require a hospital stay. • There is a 190-day lifetime limit for inpatient mental health care in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • After you use your 190 days, these services are available at an Institution for Mental Diseases (IMD). o An IMD is defined as an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. o Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. **Prior Authorization required.* *Referral required for Institution for Mental Disease Services for Individuals age 65 or older.*	$0*
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If your inpatient stay is not reasonable and necessary, the plan will not pay for it. However, in some cases the plan will pay for services you get while you are in the hospital or a nursing home. The plan will pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services **This benefit is continued on the next page**	$0 for most items* The copay is $0 for prosthetic devices/medical supplies covered by Medicare. The copay is $3.40 medical supplies covered only by Healthy Connections Medicaid. *

General services that our plan pays for	What you must pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: o replace all or part of an internal body organ (including contiguous tissue), **or** o replace all or part of the function of an inoperative or malfunctioning internal body organ. • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage wear, loss, or a change in the patient's condition • physical therapy, speech therapy, and occupational therapy **Not all outpatient diagnostic procedures, tests, and lab* services will require authorization. **Some specialized lab services (for example, genetic testing lab services) may require prior authorization. Have your provider call the plan to confirm if authorization is required.* **Medicaid prior authorization required.* **Prior Authorization is required for some services including prosthetics, physical therapy, speech therapy, occupational therapy, outpatient diagnostic, and therapeutic radiological services.*	

General services that our plan pays for		What you must pay

	Kidney disease services and supplies
	
	The plan will pay for the following services:
	• Kidney disease education services to teach kidney care and help members make good decisions about their care.
	  ○ You must have stage IV chronic kidney disease, and your doctor must refer you.
	  ○ The plan will cover up to six sessions of kidney disease education services.
	• outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, page 3, when your provider for this service is temporarily unavailable or inaccessible.
	• inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care
	• self-dialysis training, including training for you and anyone helping you with your home dialysis treatments
	• home dialysis equipment and supplies
	• certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply
	
	Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.
		$0

General services that our plan pays for		What you must pay
	Long-term services and supports (LTSS) waiver services See Section E for a more detailed description of LTSS waiver services. If you qualify for one of the Community Long Term Care (CLTC) waivers, you may also be eligible to receive certain LTSS through First Choice VIP Care Plus to help you until waiver services are available. You must talk to your care coordinator to get a referral for some LTSS services. **Prior Authorization required.*	$0*
	Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least one pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0

General services that our plan pays for	What you must pay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if your treatment is needed in the next calendar year.	$0
Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

General services that our plan pays for		What you must pay
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. First Choice VIP Care Plus will pay for the following drugs: • drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • clotting factors you give yourself by injection if you have hemophilia • immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • antigens • certain oral anti-cancer drugs and anti-nausea drugs **This benefit is continued on the next page**	$0*

General services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued) • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®,or Aranesp®) • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 explains what you pay for your outpatient prescription drugs through our plan. **Prior Authorization required.*	

General services that our plan pays for	What you must pay
Nursing home care Your plan will cover the following services: • nursing services: all nursing services to meet the total needs of the resident. • special services: assistance from social workers, planned activities, and various therapies • personal services: assistance with eating, dressing, toilet functions, baths, etc. • room and board: semi-private or ward accommodations • safety and treatment equipment: wheelchairs, infusion equipment, bedside commode, etc. • medications: over-the counter medications (except for insulin) • medical supplies and oxygen: oxygen, equipment for inhalation therapy, catheters, dressings, etc. Services that are not covered include physician services, lab/x-ray, inpatient and outpatient hospital services, prescription drugs, etc. Please note that skilled nursing facility (SNF) care is covered under its own category in this chart. **Prior Authorization required.*	Please contact your care coordinator to learn if you will need to contribute toward your nursing home care.*

General services that our plan pays for		What you must pay
	Nursing home transition services Nursing home transition services are available if you are in a nursing home and want to move back into your community. The services help if you have a disability or mental health condition. The following services are available: • appliance services which provide necessary appliances • furniture to establish a home in the community • one-time assistance with rent or utilities The Home Again program is designed to help people who have lived in a nursing home and wish to return to the community. If you lived in a nursing facility for at least 90 days, you may qualify for the program and get the following services: • transition coordination • crisis intervention • expanded employment services • expanded assistive devices • expanded goods and services • wireless sensors • community living services • guided care nurse • service animals If you think you qualify for the program, talk to your care coordinator. Nursing Home Transition services are limited to one session per year. **Prior Authorization required.* *You should talk to your provider and get a referral.*	$0*

General services that our plan pays for		What you must pay
	Nursing hotline A 24 hour per-day, seven days per-week toll-free system with access to a registered nurse who can answer questions about health concerns. The 24/7 Nurse Advice Call Line number is **1-855-843-1147 (TTY 711)**. This call is free. We have free interpreter services for people who do not speak English.	$0
🍎	**Obesity screening and therapy to keep weight down** If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
	Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0
	Outpatient blood services **Prior authorization required.*	$0*

General services that our plan pays for		What you must pay
	Over-the-Counter (OTC) items Up to $100 per quarter may be spent for over-the-counter items included in the OTC catalog and/or online ordering portal. Members may purchase up to six products per category per quarter. There is no limit on the number of items in your order. OTC orders are limited to three orders per quarter. Additional limits may apply to some items. Any unused balance will automatically expire at the end of each quarter or upon disenrollment from the plan.	$0
	Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • other outpatient diagnostic tests **Prior Authorization required.* *Not all outpatient diagnostic procedures, tests, and lab services require authorization. Have your provider call the plan to confirm if authorization is required.*	$0*

General services that our plan pays for	What you must pay

Outpatient hospital services
 	
The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
 	
The plan will pay for the following services, and maybe other services not listed here:
• services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
  ○ Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient."
  ○ Sometimes you can be in the hospital overnight and still be an "outpatient."
  ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101
• labs and diagnostic tests billed by the hospital
• mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it
• X-rays and other radiology services billed by the hospital
• medical supplies, such as splints and casts
• preventive screenings and services listed throughout the Benefits Chart
• some drugs that you can't give yourself
 	
This benefit is continued on the next page
 	
Outpatient hospital services (continued)
 	
**Prior authorization is required for some outpatient hospital services.*
 	
Authorization is not required for Medicare-covered observation services.
	$0*

General services that our plan pays for		What you must pay
	Authorization rules for outpatient hospital services are shown in the description for each individual outpatient benefit listed in the Benefits Chart. Not all outpatient hospital preventive or diagnostic services require authorization.	
	Outpatient mental health care The plan will pay for mental health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner (NP), • a physician assistant (PA), • a licensed marriage and family therapist (LMFT), • a licensed professional counselor (LPC), **or** • any other Medicare-qualified mental health care professional as allowed under applicable state laws. The plan will pay for the following services, and maybe other services not listed here: • clinic services • day treatment • psychosocial rehab services *You should talk to your provider and get a referral*	$0

General services that our plan pays for		What you must pay
	Outpatient rehabilitation services The plan will pay for physical therapy, occupational therapy, and speech therapy. Physical therapy services must improve or restore your physical function and prevent injury, impairments, and disabilities after a disease, injury, or loss of a body part. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. **Prior authorization required.*	$0*
	Outpatient substance abuse services Medicare Part B helps pay for outpatient substance abuse treatment services from a clinic or hospital outpatient department. Covered services include, but are not limited to: • psychotherapy • patient education • follow-up care after you leave the hospital • prescription drugs during a hospital stay or injected at a doctor's office. • preventive screening and counseling **Prior Authorization required.* *Not all outpatient substance abuse services will require authorization. Have your provider call the plan to confirm if authorization is required.*	$0*
	Outpatient surgery The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Prior Authorization required.*	$0*

General services that our plan pays for		What you must pay
	Palliative care Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team that may include doctors, nurses, social workers, chaplains, and others who work with a patient's other doctors to provide an extra layer of support. The team will: • talk to members about what matters most to them • assess and manage pain and other symptoms • address psychological and spiritual needs of members and their family • offer support to help members live as fully as possible • offer a support system to help the family cope during the member's illness Palliative care is appropriate at any age and at any stage in a serious illness, and it can be provided together with curative treatment. **Prior Authorization required.* *You should talk to your provider and get a referral.*	$0*

General services that our plan pays for		What you must pay
	Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. **Prior Authorization required.*	$0*
	Physician/provider services, including doctor's office visits The plan will pay for the following services: • medically necessary health care or surgery services given in places such as: o physician's office o certified ambulatory surgical center o hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment • certain telehealth services, including: o Some PCP visits o Second opinion by another network provider before a medical procedure or surgery **This benefit is continued on the next page**	$0

General services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for the diagnosis, evaluation, and treatment of mental health disorders if: o you have an in-person visit within 6 months prior to your first telehealth visit o you have an in-person visit every 12 months while receiving these telehealth services o exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o you're not a new patient **and** **This benefit is continued on the next page**	

General services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits (continued) ○ the check-in isn't related to an office visit in the past 7 days **and** ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: ○ you're not a new patient **and** ○ the evaluation isn't related to an office visit in the past 7 days **and** ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to: ○ surgery of the jaw or related structures, ○ setting fractures of the jaw or facial bones, ○ pulling teeth before radiation treatments of neoplastic cancer, **or** ○ services that would be covered when provided by a physician.	
	Podiatry services The plan will pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	$0

General services that our plan pays for		What you must pay
	Prostate cancer screening exams For men, the plan will pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here if your provider gets prior approval: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section for details. The plan will not pay for prosthetic dental devices. **Prior Authorization is required*	The copay is $0 for prosthetic devices/medical supplies covered by Medicare. The copay is $3.40 for medical supplies covered only by Healthy Connections Medicaid. *

General services that our plan pays for		What you must pay
	Pulmonary rehabilitation services The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. **Prior Authorization required.*	$0*
	Respite Care Services Respite care can be provided in a Community Residential Care Facility (CRCF), a nursing facility, or at your home. Up to 28 days of respite care can be in a CRCF. Up to 14 days of respite care can be in a nursing facility. Up to 14 days of respite care can be in your home. The care you are qualified for depends on your situation. If you qualify for one of the Community Long Term Care (CLTC) waivers, you may be eligible to receive *certain* long-term services and supports including respite through First Choice VIP Care Plus until waiver services are available. No copays will be applied to the supplemental benefit. Your care coordinator can authorize these services based on medical necessity for up to an additional 14 days per year. **Prior Authorization required.* *You must talk to your provider and get a referral.*	$0*

General services that our plan pays for		What you must pay
	Sexually transmitted infections (STIs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months. The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
	Skilled nursing facility (SNF) care The plan will pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration **This benefit is continued on the next page**	$0*

General services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care (continued) • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital • Please note that nursing home care is covered under its own category in this chart. The plan does not require an inpatient hospital stay before admitting you to a SNF. Community and Long Term Care (CLTC) certification is required prior to any Medicaid-sponsored admission to a long-term care facility from any location, including a move from the community to a nursing facility stay (stay not covered by Medicare or less than three day hospital stay prior to nursing facility admission). SNF admission must meet medical necessity standards. You must talk to your care coordinator to get a referral for Healthy Connections Medicaid-covered stays. The health plan will be notified of a member's admission to a Medicaid-sponsored long-term care facility stay. The stay is required by a licensed nursing facility. **Prior authorization is required for Medicare-covered SNF services.*	

General services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques **Prior authorization required.*	$0*

General services that our plan pays for		What you must pay
	Targeted Case Management (TCM) TCM activities make sure that your medical, social, educational and other service needs are addressed on an ongoing basis to help you become more self-sufficient. To get TCM, you have to be in one of the following groups: • individuals with intellectual and related disabilities • adults with serious and persistent mental illness • individuals with psychoactive substance disorders • individuals at-risk for genetic disorders • individuals with head and spinal cord injuries and related disabilities • individuals with sensory impairments • adults with functional impairments TCM is only available for the last 180 days that you are in an institution and are moving to a community setting. Individuals who are moving into a waiver are not eligible for TCM. Talk to your care coordinator or PCP about getting TCM services. **Prior Authorization required.*	$0*

General services that our plan pays for		What you must pay
	Telemedicine The plan covers some medical or health services using real-time audio or video with a provider who isn't at your location. These services are available in some rural areas, under certain conditions, and only if you're located at one of the following places: a doctor's office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility (SNF), or community mental health center. The following services are covered using a telecommunication system: • consultation • office visits • individual psychotherapy • prescription management • psychiatric diagnostic interview exams and testing Services such as telephone conversations, e-mail messages and video cell phone calls are not covered. Tele-psychiatry is only provided on a limited basis through the Department of Mental Health in partnership with over 20 hospital emergency rooms in the state. MDLive offers all members 24/7 access throughout the year to a participating doctor via telephone, desktop, or mobile device. Members have the ability to immediately have a medical, counseling, or psychiatry consultation with a physician. Members can also schedule a telemedicine appointment for a later time. *You should talk to your provider and get a referral.*	$0
	Telemonitoring Telemonitoring equipment monitors members weight, blood pressure, blood oxygen and glucose levels. Daily readings are transmitted from the members home to nurses who review the daily results. Doctors are notified if readings are outside of certain ranges.	$0

General services that our plan pays for		What you must pay
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). Urgent care is only covered when you get the services in the U.S.	$0
	**Vision care** The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Medicare does not cover regular eye exams for glasses or contacts. Healthy Connections Medicaid covers the following services: • treatment for an illness or injury to the eye • initial replacement of the lens due to cataract surgery* For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, **Benefit Continued on next page**	$0*

General services that our plan pays for	What you must pay
Vision care (continued) • people with diabetes, • African-Americans who are age 50 and older, **and** • Hispanic Americans who are 65 or older. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also pay for corrective lenses and frames, and replacements if you need them after a cataract removal without a lens implant. **Routine Vision** • One routine eye exam every year, excluding contact lens exam and fitting services. • One pair of eyeglasses (lenses and frames) or one pair of contact lenses is covered every two years. • There is a $150 plan coverage limit for eyewear every two years. Up to $150 can be applied towards eyeglasses or contact lenses every two years. **Prior authorization required for Initial replacement of the lens due to cataract surgery.*	

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

E. Waiver Services Operated by Community Long Term Care (CLTC) that Our Plan Pays For

Long-term services and supports (LTSS) help meet your daily needs for assistance and help improve the quality of your life. LTSS can help you with everyday tasks like taking a bath, getting dressed, and making food. Most of these services are provided in your home or in your community, but they could also be provided in a nursing home or hospital.

LTSS are available to members who are on certain waiver programs operated by the Community Long Term Care (CLTC) division of Healthy Connections Medicaid. The type and amounts of LTSS depend on the waiver you are on. If you think you need LTSS, you can talk to your care coordinator about how to access them and whether you can join one of these waivers.

Waiver services operated by Community and Long Term Care (CLTC) that our plan pays for	What you must pay
Community Choices Waiver services The plan provides extra services for members on the Community Choices Waiver. These services include: • adult day health care and nursing • transportation to adult day health care • case management and coordination of these waiver services • companion services • home delivered meals • minor home adaptations (for example, ramp, pest control, handheld shower equipment) • personal and attendant care • personal emergency response system • some nutritional supplements • specialized medical equipment and supplies • temporary relief for your caregiver in a Community Residential Care Facility (CRCF) or an in-patient facility (nursing facility or hospital) **Benefit Continued on next page**	$0*

Waiver services operated by Community and Long Term Care (CLTC) that our plan pays for		What you must pay
	Community Choices Waiver services (continued) Our HCBS Supplemental Benefit includes certain waiver services, which can be provided to members who are not currently enrolled in a waiver but who meet eligibility for the waiver, for a temporary period of time, to prevent or delay hospital or long-term nursing home placement. These services are personal care, companionship, bath safety equipment, and up to an additional 14 days per year of respite services provided in the home or in an institution. Care Coordinators must authorize these services for members who meet the criteria. **Prior Authorization required.*	

Waiver services operated by Community and Long Term Care (CLTC) that our plan pays for		What you must pay
	HIV/AIDS Waiver services The plan provides extra services for members on the HIV/AIDS Waiver. These services include: • case management and coordination of these waiver services • companion services • home delivered meals • minor home adaptations (for example, ramp, pest control, handheld shower equipment) • personal and attendant care • private duty nursing • some nutritional supplements Our HCBS Supplemental Benefit includes certain waiver services, which can be provided to members who are not currently enrolled in a waiver but who meet eligibility for the waiver, for a temporary period of time, to prevent or delay hospital or long-term nursing home placement. These services are personal care, companionship, bath safety equipment, and up to 14 days per year of respite services provided in the home or in an institution. Care Coordinators must authorize these services for members who meet the criteria. **Prior Authorization required.*	$0*

Waiver services operated by Community and Long Term Care (CLTC) that our plan pays for		What you must pay
	Mechanical Ventilator Dependent Waiver services The plan provides extra services for members on the Mechanical Ventilator Dependent Waiver. These services include: • case management and coordination of these waiver services • home delivered meals • minor home adaptations (for example, ramp, pest control, handheld shower equipment) • personal and attendant care • personal emergency response system • private duty nursing • some nutritional supplements • specialized medical equipment and supplies • temporary relief for your caregiver (in a nursing facility or at your home) Our HCBS Supplemental Benefit includes certain waiver services, which can be provided to members who are not currently enrolled in a waiver but who meet the eligibility for the waiver, for a temporary period of time, to prevent or delay hospital or long term nursing home placement. These services are personal care, companion, bath safety equipment, and up to 14 days per year of respite services provided in the home or in an institution. Care Coordinators must authorize these services for members who meet the criteria. **Prior Authorization required*	$0*

F. Benefits covered outside of First Choice VIP Care Plus

The following services are not covered by First Choice VIP Care Plus but are available through Medicare. You can get these services in the same way that you do today.

F1. Hospice care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what First Choice VIP Care Plus pays for while you are getting hospice care services.

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

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

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

For drugs that may be covered by First Choice VIP Care Plus's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F3, page 18.

Note: If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

The following services are not covered by First Choice VIP Care Plus but are available through Healthy Connections Medicaid. You can get these services in the same way that you do today.

F2. Dental services

Diagnostics (oral evaluation and x-rays), preventive care (annual cleaning), restorative care (fillings), and surgical care (extractions/removals) are covered on a fee-for-service basis with a $3.40 copay. Please contact your care coordinator for more information.

F3. Non-emergency medical transportation

Transportation assistance is available to and from any medical appointment with a $0 copay. The type of assistance will depend on the member's medical situation. Requests for urgent or same day requests (such as transportation assistance for routine hospital discharges) will be verified with health care providers to confirm that the short timing is medically necessary. **Any member needing emergency transportation should call 911.**

For more information, please contact your care coordinator or refer to the member brochure located at the website of ModivCare, who is the transportation broker: memberinfo.logisticare.com/scmember/Downloads. If you have additional questions, please contact ModivCare using the contact information for your region in the member brochure.

G. Benefits not covered by First Choice VIP Care Plus, Medicare, or Healthy Connections Medicaid

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

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

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

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

- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Dentures. However, dental care required to treat illness or injury may be covered as inpatient or outpatient care

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Radial keratotomy, LASIK surgery, and other low-vision aids. However, the plan will pay for glasses after cataract surgery.
- Full-time nursing care in your home.
- Naturopath services (the use of natural or alternative treatments).
- Non-prescription contraceptive supplies.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Personal items in your room at a hospital or a nursing home, such as a telephone or a television.
- Private room in a hospital, except when it is medically necessary.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Services considered not “reasonable and necessary,” according to the standards of Medicare and Healthy Connections Medicaid, unless these services are listed by our plan as covered services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

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

First Choice VIP Care Plus also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing home.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in Chapter 4, Section D, page 5.

Rules for the plan's outpatient drug coverage

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

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
    - If it is not on the Drug List, we may be able to cover it by giving you an exception.
    - Refer to Chapter 9, Section F, page 5, to learn about asking for an exception.
5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

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

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

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

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment 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 pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, refer to Chapter 7, Section A, page 2.
- If you need help getting a prescription filled, you can contact Member Services or your care coordinator.

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

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

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

A4. What to do if your pharmacy leaves the network

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

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

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
    - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have any difficulty getting your drugs in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that 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 find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A6. Using mail-order services to get your drugs

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

Our plan's mail-order service requires you to order at least a 61-day supply and no more than a 100-day supply. A 61-100-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please contact Member Services at the number at the bottom of the page, or visit the plan website.

Usually, a mail-order prescription will get to you within 10-business days. However, sometimes your mail-order may be delayed. If you experience a delay, please call **1-800-345-1985 (TTY 711),** 24 hours a day.

If you need your medication urgently and cannot wait 10-business days to get your order, please contact the Walgreens Customer Care Center at **1-800-345-1985 (TTY 711),** 24 hours a day, to avoid a gap in medication therapy.

- When calling the Walgreens Customer Care Center with an urgent request, press “0” twice on your phone. Be prepared to answer a few identifying questions. You will then be connected to a representative.
- Tell the Walgreens Customer Care representative that you have less than a 10-day supply of medication and need your order expedited (rush delivery). The Customer Care Center representative will discuss available options with you.
- Let the representative know the following information:
    - Your name, address, phone number, date of birth, medication name(s), medication dosage(s), how many days of the medication(s) you have left, the name of the person(s) who prescribed the medication(s), and your insurance (First Choice VIP Care Plus).
- The Customer Care Center will offer shipping options available to help rush a medication order to you. The Customer Care Center representative will confirm the following information with you: 1) the option you chose for getting a rush order, 2) your mailing address, 3) the potential estimated time of arrival, and 4) an order number for reference and confirmation.
- A rush-order can include overnight shipping to three day shipping. The shipping method depends on how much medication you have left and when you contact the Walgreens Customer Care Center. For next-day delivery, you will need to contact the Walgreens Customer Care Center by 2 p.m., Eastern Time, Monday through Friday.
- Walgreens may need to contact the person who prescribed the medication or your insurance if your prescription has expired, if authorization is needed, or for other reasons. This kind of information might be needed before the order is shipped to you.
- The Walgreens Customer Care Center may also be able to arrange for you to get a short-term supply while you are waiting for your mail order. You can ask the Walgreens Customer Care representative about getting a short-term supply.

- If you do not get your medication mail order when Walgreens says it will arrive, call the Walgreens Customer Care Center at 1-800-345-1985. Press “0” twice on your phone. Be prepared to answer a few identifying questions. You will then be connected to a representative.

Mail-order process

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

1. New prescriptions the pharmacy gets from you

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

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

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

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

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 10-business days before your current prescription will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you.

In order for the mail-order pharmacy to reach you, they must have a valid telephone number on file for you. You can ensure your information is up to date with your mail-order pharmacy by telephone, on their website, or with the refill slip that is provided with each refill order.

A7. Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 61-100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

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

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

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

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

- If the prescriptions are related to care for a medical emergency or urgent care.
- If you are unable to obtain a covered drug in a timely manner within our service areas because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- 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 administered in the doctor's office.
- When it is declared a disaster or state of emergency by the government, we allow access to out-of-network facilities to prevent an interruption in service.

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

A9. Paying you back if you pay for a prescription

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

To learn more about this, refer to Chapter 7, Section A, page 2.

B. The plan's Drug List

The plan has a Drug List.

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

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

B1. Drugs on the Drug List

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

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 such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. 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 brand name drugs or biological products and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

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

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

B2. How to find a drug on the Drug List

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

- Check the most recent Drug List we sent you in the mail.
- Visit our website listed at the bottom of the page. The Drug List on our website is always the most current one.
- Call Member Services at the number at the bottom of the page and to find out if a drug is on the plan's Drug List or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.firstchoicevipcareplus.com or call your care coordinator or Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.
- Contact your care coordinator by calling **1-888-978-0862 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m.

B3. Drugs that are not on the Drug List

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

First Choice VIP Care Plus will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9, Section D, page 6.)

Here are three general rules for excluded drugs:

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

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

- 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
- drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of three tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1 includes Part D generic drugs. Tier 1 is the lowest tier.
- Tier 2 includes Part D brand name drugs and some generic drugs.
- Tier 3 includes Healthy Connections Medicaid (non-Part D) covered prescription and over-the-counter (OTC) drugs. Tier 3 is the highest tier.

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

Chapter 6, Section C, page 5 tells the amount you pay for drugs in each tier.

C. Limits on some drugs

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

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

To learn more about asking for exceptions, refer to Chapter 9, Section F3, page 26.

1. Limiting use of a brand name drug or original biological products when a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. If there is a generic or interchangeable biosimilar version of a brand name drug or original biological product, our network pharmacies will give you the generic or interchangeable biosimilar version.

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

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from First Choice VIP Care Plus before you fill your prescription. If you don't get approval, First Choice VIP Care Plus may not cover the drug.

3. Trying a different drug first

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

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

4. Quantity limits

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

Find out if these rules apply to your drugs

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services at the number at the bottom of the page or check our website listed at the bottom of the page.

D. Reasons your drug might not be covered

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

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

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

D1. Getting a temporary supply

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

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

1. The drug you have been taking:
   - is no longer on the plan's Drug List, **or**
   - was never on the plan's Drug List, **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in the plan last year.
     - We will cover a temporary supply of your drug **during the first 180 days of the calendar year**.
     - This temporary supply will be for up to 30 days of Part D prescriptions and 90 days of non-Part D prescriptions or items.
     - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of Part D medication or 90 days of non-Part D medication. You must fill the prescription at a network pharmacy.

- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You are new to the plan.
  - We will cover a temporary supply of your drug during the first 180 days of your membership in the plan.
  - This temporary supply will be for up to 30 days of Part D medication or 30 days of non-Part D medication. If you are in long-term care, we will provide 31 days of Part D drugs.
  - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You have been in the plan for more than 180 days and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply of Part D drugs and 90 days of non-Part D prescriptions or items, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

Members who have a change in level of care (setting) will be allowed up to a one-time 30-day transition supply per drug no matter what type of prescription it is. For example, members who:

- Enter long-term care (LTC) facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary, with very short-term planning taken into account (often under eight hours).
- Are discharged from a hospital to home.
- End their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary.
- End a long-term care facility stay and return to the community.

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

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

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

- You can change to another drug.

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

  OR

- You can ask for an exception.

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

To learn more about asking for an exception, refer to Chapter 9, Section F, page 23.

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

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but First Choice VIP Care Plus may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval (PA) for a drug. (PA is permission from First Choice VIP Care Plus before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

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

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

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

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

- Check First Choice VIP Care Plus's up to date Drug List on our website listed at the bottom of the page **or**
- Call Member Services at the number at the bottom of the page to check the current Drug List.

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

- **A new generic drug becomes available**. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug but your cost for the new drug will stay the same.
- When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.
    - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
    - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9, Section F, page 23 of this handbook for more information on exceptions.
- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. Please contact the prescribing doctor if you have any questions.

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

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

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9, Section F, page 23.

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

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

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

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

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

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

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

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

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

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

To learn more about the hospice benefit, refer to Chapter 4, Section D, page 5.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

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

- may not be needed because you are taking another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

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

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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

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

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

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

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

First Choice VIP Care Plus has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. 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. Limitations may include:

- Requiring you to get all prescriptions for those medications **from certain pharmacies** and/or **from certain doctors**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

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

Introduction

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

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

Because you are eligible for Healthy Connections Medicaid, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

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

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

- The plan’s *List of Covered Drugs*.
    - We call this the “Drug List.” It tells you:
        - Which drugs the plan pays for
        - Which of the three tiers each drug is in
        - Whether there are any limits on the drugs
    - If you need a copy of the Drug List, call Member Services at the number at the bottom of the page. You can also find the Drug List on our website listed at the bottom of the page. The Drug List on our website is always the most current.
- Chapter 5 of this *Member Handbook***.**
    - Chapter 5, Section A, page 4 tells how to get your outpatient prescription drugs through the plan.

- It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.

- The plan's *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, page 4.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your care coordinator or Member Services for more information.

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A. The *Explanation of Benefits* (EOB)

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

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

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to the Drug List.

B. How to keep track of your drug costs

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

1. **Use your Member ID Card.**

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

2. **Make sure we have the information we need.**

Give us copies of receipts for covered drugs that you have paid for. You can ask us to pay you back for the drug.

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

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

To learn how to ask us to pay you back for the drug, refer to Chapter 7, Section A, page 2.

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

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. Check the EOBs we send you.

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

C. You pay nothing for a one-month or long-term supply of drugs

With First Choice VIP Care Plus, you pay nothing for covered drugs as long as you follow the plan's rules.

C1. The plan's cost-sharing tiers

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of three (3) tiers. You have no copays for prescription and OTC drugs on First Choice VIP Care Plus's Drug List. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are Medicare Part D covered generic drugs. The copay is $0.
- Tier 2 drugs are Medicare Part D brand name drugs and some generic drugs. The copay is $0

- Tier 3 drugs are Non-Medicare covered prescription and over-the-counter (OTC) drugs covered by Healthy Connections Medicaid. The copay is $0.

C2. Your pharmacy choices

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

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

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5, Section A8, page 8 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5, Section A, page 4 in this handbook and the plan's *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5, Section A, page 4 or the *Provider and Pharmacy Directory*.

C4. What you pay

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

	A network pharmacy A one-month or up to a 100-day supply	**The plan's mail-order service** A 61-100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5, Section A, for details.
Tier 1 **(Part D generic drugs)**	**$0**	**$0**	**$0**	**$0**
Tier 2 **(Part D Brand and some generic drugs)**	**$0**	**$0**	**$0**	**$0**
Tier 3 **(Non-Medicare prescription/OTC Drugs)**	**$0**	**$0**	**$0**	**$0**

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

D. Vaccinations

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs* (*Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

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

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

D1. What you need to know before you get a vaccination

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

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers. **Network pharmacies** are pharmacies that have agreed to work with our plan. A **network provider** is a provider who works with the health plan. A network provider should work with First Choice VIP Care Plus to ensure that you do not have any upfront costs for a Part D vaccine.

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

Introduction

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

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A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, refer to Section B, page 4.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid the bill, it is your right to be paid back.
    - If you paid for services covered by Medicare, we will pay you back.
    - If you paid for services covered by Healthy Connections Medicaid, we can't pay you back, but the provider will. Member Services or the Healthy Connections Prime Advocate can help you contact the provider's office. Refer to the bottom of the page and Chapter 2, Section H, page 12 for their phone numbers.
- If the services or drugs are **not** covered, we will tell you.

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

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

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

   You should ask the provider to bill the plan.

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

2. When a network provider sends you a bill

Network providers must always bill the plan. Show your First Choice VIP Care Plus Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills you do not understand.**

- Because First Choice VIP Care Plus pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We will pay you back for your covered services.

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

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

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Please refer to Chapter 5, Section A8, page 8 to learn more about out-of-network pharmacies.

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

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

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

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

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

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
    - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9, Section D, page 6).
    - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9, Section E, page 10).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

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

To learn how to make an appeal, refer to Chapter 9, Section D, page 6.

B. Sending us a request for payment

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

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

For Medical Services:	**For Drugs:**
First Choice VIP Care Plus P.O. Box 7107 London, KY 40742-7107	First Choice VIP Care Plus Attention: Direct Member Reimbursement P.O. Box 516 Essington, PA 19029

You must submit your claim to us within 365 days of the date you got the service, item, or drug.

C. Coverage decisions

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

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

Chapter 3, Section B page 3 explains the rules for getting your services covered. Chapter 5, Section A, page 4 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9, Section D, page 6.

D. Appeals

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

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

- If you want to make an appeal about getting paid back for a health care service, refer to page 10.
- If you want to make an appeal about getting paid back for a drug, refer to page 23.

Chapter 8: Your rights and responsibilities

Introduction

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

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

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about the plan's options, rules, and benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials for free in Spanish and in formats such as large print, braille, or audio.
- You can make a request to get information, now and in the future, in a language other than English or in another format simply by calling Member Services at **1-888-978-0862 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m. We'll also ask for your preference during our Welcome Call and later in the year, when you contact the plan. The plan will store your request and continue to send future documents in Spanish language or requested format, unless you ask us to cancel or change the request. You can cancel or change your request at any time, simply by calling Member Services. The calls are free.

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Medicaid at 1-888-549-0820. (TTY: 1-888-842-3620)
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697
- You can also call Healthy Connections Medicaid directly for help with problems. Here is how to get help from Healthy Connections Medicaid:
    - Call the Healthy Connections Prime Advocate at 1-844-477-4632. They can help you understand the complaint process and tell you who can help. TTY users should call 711.

A. Usted tiene derecho a obtener información de una manera que se adapte a sus necesidades

- Tenemos la obligación de avisarle sobre las opciones, reglas y beneficios del plan, de una manera que usted pueda entenderlo. Tenemos la obligación de avisarle cuáles son sus derechos cada año que usted esté en nuestro plan.
- Para obtener información de una manera que pueda entender, llame a Servicios al miembro. Nuestro plan tiene personas que pueden responder preguntas en diferentes idiomas. Nuestro plan también tiene materiales impresos disponibles en español. También podemos darle información gratuita en Braille o en letras grandes. También podemos darle información en Braille o letra grande.
- Nuestro plan también puede proporcionarle materiales sin cargo en español y en formatos como letra grande, Braille o audio. Para solicitar recibir información, ahora y en el futuro, en un idioma distinto del inglés o en otro formato, llame a Servicios al Miembro al **1-888-978-0862 (TTY 711)**, los siete días de la semana, de 8 a.m. a 8 p.m. También le preguntaremos qué prefiere en nuestra llamada de bienvenida y cuando se comunique con el plan en otro momento del año. El plan conservará su solicitud y continuará enviando los documentos futuros en el idioma o formato solicitados, a menos que nos solicite que cancelemos o cambiemos la solicitud. Puede cancelar o cambiar su solicitud en cualquier momento simplemente llamando a Servicios al Miembro. Las llamadas son gratuitas.
- Si tiene problemas para obtener información de su plan por problemas de idioma o alguna discapacidad y quiere presentar una queja, llame a Medicare al 1-800- MEDICARE (1-800-633-4227). Puede llamar las 24 horas al día, siete días a la semana. Los usuarios de TTY (personas con dificultades para oír o hablar) deberán llamar al 1-877-486-2048.
- Medicaid al 1-888-549-0820. (TTY: 1-888-842-3620)
- Office of Civil Rights al 1-800-368-1019 or TTY 1-800-537-7697
- También puede llamar directamente a Healthy Connections Medicaid para que le ayuden con problemas. Lea abajo sobre cómo obtener ayuda de Healthy Connections Medicaid:
    - Llame al Defensor primario de Healthy Connections al 1-844-477-4632. Ellos pueden ayudarle a entender el proceso de quejas y le dirán quién puede ayudarle. Los usuarios de TTY deberán llamar a 711.

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

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3, Section D1, page 6.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a network of primary care and specialty providers who are capable of meeting your needs such as physical location, communication, and scheduling.
- You have the right to use a women's health specialist without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3, Section D4, page 9.

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

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

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

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

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

C1. How we protect your PHI

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

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

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

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

C2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.

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

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

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

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

As a member of First Choice VIP Care Plus, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at **1-888-978-0862 (TTY 711)**. This is a free service. We also have written materials available in Spanish. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how the plan has been rated by plan members
  - the number of appeals made by members
  - how to leave the plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - a list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services or visit our website listed at the bottom of the page.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and rules you must follow, including:
  - services and drugs covered by the plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs

- Why something is not covered and what you can do about it, (refer to Chapter 9) including asking us to:
    - put in writing why something is not covered
    - change a decision we made
    - pay for a bill you got

As a member of First Choice VIP Care Plus, you have the right to get timely information about any changes to the plan. This includes getting written information listed in your orientation materials once per year and being notified of any major changes in your orientation materials 30 days before those changes happen.

E. Inability of network providers to bill you directly

You have financial rights. Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7, Section A, page 2.

You have the right to be protected from paying any fees that First Choice VIP Care Plus is responsible for.

You have the right to not be charged any cost sharing (copays and deductibles) for Medicare Parts A and B services.

F. You have the right to leave the plan at any time

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- If you leave the plan, you will get your Healthy Connections Medicaid benefits the way you used to before you joined. They will be offered through Healthy Connections Medicaid fee-for-service.
- Refer to Chapter 10, Section D, page 3 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your health care

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

- **Know your health status.** You have the right to have complete and accurate information about your health status.
- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section D, page 6 tells how to ask the plan for a coverage decision.
- **Be encouraged to involve caregivers and family members in treatment discussions and decisions.**
- **Be told in advance, in writing, if you are transferred to another treatment location and the reason for that transfer.**

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

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

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

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

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

- **Get the form.** You can get a form from your doctor, your care coordinator, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Healthy Connections Medicaid, such as I-CARE (South Carolina's State Health Insurance Program, or SHIP), may also have advance directive forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**

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

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

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

G3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your care coordinator or the Healthy Connections Prime Advocate.

H. Your right to have a voice in how the plan is operated

If you have feedback on how the plan is operated today, please call Member Services at the number at the bottom of the page to let us know.

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

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

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

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed in Chapter 11 of this handbook – or you would like more information about your rights, you can get help by calling:

- Member Services.
- I-CARE, the State Health Insurance Assistance Program (SHIP). For details about this organization and how to contact it, refer to Chapter 2, Section D, page 7.
- The Healthy Connections Prime Advocate. For details about this organization and how to contact it, refer to Chapter 2, Section H, page 12.
- 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. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- Healthy Connections Medicaid at 1-888-549-0820, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-888-842-3620.

J. Your responsibilities as a member of the plan

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

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6.
- **Participate in an initial health screen** upon enrollment in the plan. For more information, refer to Chapter 1, Section F, page 7 or call Member Services.
- **Participate in a comprehensive assessment** within the first 60 or 90 days of enrollment. For more information, refer to Chapter 1, Section F, page 7 or call Member Services.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For almost all First Choice VIP Care Plus members, Healthy Connections Medicaid pays for your Part A premium and for your Part B premium.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
    - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get First Choice VIP Care Plus. Chapter 1, Section D, page 6 tells about our service area.
    - We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area.
    - Also, be sure to let Medicare and Healthy Connections Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Healthy Connections Medicaid.
    - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Pay estate recovery amounts after your death**
    - Estate recovery is the amount that certain members owe Healthy Connections Medicaid after their death.
    - You will not owe our plan any money, but you may owe money to Healthy Connections Medicaid for services you received before you joined our plan.
    - The plan is not allowed to collect estate recoveries after your death, but we will notify Healthy Connections Medicaid that you have died.
    - If you owe Healthy Connections Medicaid money when you die, the state may collect estate recoveries from money or property you leave behind.
- Call Member Services for help if you have questions or concerns.

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

Introduction

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

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

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

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call the Healthy Connections Prime Advocate at 1-844-477-4632 for help.** TTY users should call 711. This call is free. This chapter explains the different options you have for different problems and complaints, but you can always call the Healthy Connections Prime Advocate to help guide you through your problem.

Healthy Connections Prime Advocate is the ombudsman for South Carolina. For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section H, page 12 for more information on ombudsman programs.

Table of Contents

A. What to do if you have a problem

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

A1. About the legal terms

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

For example, we will say:

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

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

B. Where to call for help

B1. Where to get more information and help

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

You can get help from the Healthy Connections Prime Advocate

If you need help, you can always call the Healthy Connections Prime Advocate. The Healthy Connections Prime Advocate is an ombudsman program that can answer your questions and help you understand what to do to handle your problem. The Healthy Connections Prime Advocate is not connected with us or any insurance company or health plan. They can help you understand which process to use. The phone number for the Healthy Connections Prime Advocate is 1-844-477-4632. TTY users should call 711. This call is free and so are the services. Refer to Chapter 2, Section H page 12, for more information on ombudsman programs.

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

You can also call your State Health Insurance Assistance Program (SHIP). SHIP counselors can answer your questions and help you understand what to do to handle your problem. The SHIP is not connected with us or with any insurance company or health plan. The SHIP has trained counselors in every state, and services are free. In South Carolina, the SHIP is known as I-CARE, which stands for Insurance Counseling Assistance and Referrals for Elders. The phone number for I-CARE is 1-800-868-9095 and their website is: aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud. TTY users should call 711. These calls are free and so are the services.

Getting help from Medicare

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

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

Getting help from Healthy Connections Medicaid

You can call Healthy Connections Medicaid directly for help with problems. Here are some ways to get help from Healthy Connections Medicaid:

- Call Healthy Connections Medicaid at 1-888-549-0820, from Monday to Friday from 8:00 am to 6:00 pm. TTY: 1-888-842-3620. The call is free.
- Visit the Healthy Connections Medicaid website (www.scdhhs.gov).

Getting help from other resources

You can get help from other resources such as:

- Protection & Advocacy for People with Disabilities (P&A) toll free at 1-866-275-7273. TTY: 1-866-232-4525.
- South Carolina Legal Services toll free at 1-888-346-5592.
- KEPRO Quality Improvement Organization (QIO) toll-free at 1-888-317-0751 (TTY: 711) or www.keproqio.com.

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making a complaint

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

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.)	
Yes. My problem is about benefits or coverage. Refer to **Section D: "Coverage decisions and appeals"** on page 6.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 48.

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

What is a coverage decision?

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

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

What is an appeal?

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

D2. Getting help with coverage decisions and appeals

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

You can ask any of these people for help:

- Call **Member Services** at **1-888-978-0862 (TTY 711)**.
- Call the **Healthy Connections Prime Advocate** for free help. The Healthy Connections Prime Advocate helps people enrolled in Healthy Connections Prime with service or billing problems. The phone number is 1-844-477-4632. TTY users should call 711.
- Call the **State Health Insurance Assistance Program (SHIP)**, known as I-CARE in South Carolina, for free help. The SHIP is an independent organization. It is not connected with this plan. The phone number is 1-800-868-9095. TTY users should call 711.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. The form gives the person permission to act for you. You must give us a copy of the signed form.

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

D3. Using the section of this chapter that will help you

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

- **Section E on page 10** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
    - You are not getting medical care you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
        - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, in Tier 3 are **not** covered by Part D. Refer to Section F on page 23 for Part D drug appeals.
    - You got medical care or services you think should be covered, but we are not paying for this care.
    - You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
    - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
        - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 34 and 41.
    - Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your

request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, 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, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- **Section F on page 23** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior authorization (PA) or approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section G on page 34** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section H on page 41** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at the number at the bottom of the page.

If you need other help or information, please call the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users should call 711.

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical services, behavioral health services, and long-term services and supports (LTSS). You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List in Tier 3 are **not** covered by Part D. Use Section F for Part D drug appeals.

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

1. You think we cover medical services, behavioral health services, or long-term services and supports (LTSS) you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 11 for information on asking for a coverage decision.

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

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 13 for information on making an appeal.

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

   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 13 for information on making an appeal.

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

   What you can do: You can ask us to pay you back. Refer to Section E5 on page 21 for information on asking us for payment.

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

   What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 13 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections G or H on pages 34 and 41 to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get medical services, behavioral health, services or long-term services and supports (LTSS)

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

- You can call us at: **1-888-978-0862 (TTY 711)**
- You can fax us at: **1-888-257-7960**
- You can write to us at:

First Choice VIP Care Plus
Prior Authorization Department
PO BOX 7107
London, KY 40742-7107

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1**-888-978-0862 (TTY 711)** or fax us at 1-888-257-7960. For details on how to contact us, refer to Chapter 2, Section A, page 2.
- You can also have your doctor or your representative call us.

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

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

1. You can get a fast coverage decision **only if you are asking for coverage for medical care or medical items and/or services you have not yet received.** (You cannot ask for a fast coverage decision if your request is about payment for items or services you already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.**
    - If your doctor says that you need a fast coverage decision, we will automatically give you one.
    - If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
        - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
        - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
        - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, Refer to Section J on page 48.

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

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

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

E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call the Healthy Connections Prime Advocate at 1-844-477-4632 (TTY users should call 711). The Healthy Connections Prime Advocate is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

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

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

At a glance: How to make a Level 1 Appeal

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

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

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor, other provider, or your representative must contact us. You can call us at 1-888-978-0862 (TTY 711). For additional details on how to reach us for appeals, refer to Chapter 2, Section A, page 2.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
    - You can submit a request to the following address:
      First Choice VIP Care Plus
      Attn: Appeals Department
      P.O. Box 80109
      London, KY 40742-0109
    - You may also ask for an appeal by calling us at **1-888-978-0862 (TTY 711).**

The legal term for “fast appeal” is **“expedited reconsideration.”**

Can someone else make the appeal for me?

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

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at www.firstchoicevipcareplus.com/member/english/2024/resources/forms.aspx.

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

How much time do I have to make an appeal?

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

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

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 appeals" on page 42 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at the number at the bottom of the page.

Can my doctor give you more information about my appeal?

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

How will we make the appeal decision?

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

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

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

We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 48.
- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Healthy Connections Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 17.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Healthy Connections Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 17.

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

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

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 48.

- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Healthy Connections Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 17.

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

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Healthy Connections Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 17.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice at least 10 calendar days before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits while the appeal is pending. You must **make the request on or before the later of the following** in order to continue your benefits:

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

If you meet this deadline, you can keep getting the disputed service while your appeal is processing. If your benefits are continued and the final result of the appeal upholds our action, we may recover the cost of the services provided to you while the appeal was pending.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

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

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

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Healthy Connections Medicaid** service or item, you can file a Level 2 Appeal yourself with the Division of Appeals and Hearings. The letter will tell you how to do this. Information is also below.

- If your problem is about a service or item that could be **covered by both Medicare and Healthy Connections Medicaid**, you will automatically get a Level 2 Appeal with the IRE for a review regarding Medicare coverage. You can also ask for a Level 2 Appeal with the Division of Appeals and Hearings for a review regarding Medicaid coverage.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan. It is either the Independent Review Entity (IRE) or it is the Division of Appeals and Hearings. The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work.

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

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

If you want to request a State Fair Hearing, you must contact the Division of Appeals and Hearings in writing. You must ask for a State Fair Hearing **within 120 calendar days** of the date of our Level 1 decision, unless the Division of Appeals and Hearings extends the deadline for you.

You can ask for a State Fair Hearing by filing your request online at msp.scdhhs.gov/appeals.

You can also deliver your request in person, fax your request to 803-255-8206, or write to:

Division of Appeals and Hearings
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

If a hearing is granted, the Division of Appeals and Hearings will mail you a notice giving the time, date, and place of the hearing. During the hearing, an impartial hearing officer will listen to your explanation of why you do not agree with our action. The hearing officer will also listen to our explanation of the action taken. The hearing officer will ask questions to get enough information to decide if your case was handled correctly.

- The Division of Appeals and Hearings must give you a hearing decision within 90 calendar days of the date you filed an appeal with the plan.
- If you qualify for a fast review, the Division of Appeals and Hearings will give you a hearing decision within 3 business days.
    - However, if the Division of Appeals and Hearings needs to gather more information that may benefit you, it can take up to 14 more calendar days.

- If the Division of Appeals and Hearings needs extra days to make a decision, it will tell you by letter.

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

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

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at the number at the bottom of the page.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item is covered by both Medicare and Healthy Connections Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Healthy Connections Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity for a review regarding Medicare coverage. You can also submit a Level 2 Appeal to the Division of Appeals and Hearings for a review regarding Healthy Connections Medicaid coverage. Follow the instructions on page 20.

Will my benefits continue during Level 2 appeals?

If we decide to change or stop coverage for a service that was previously approved, you can ask to continue your benefits during Level 2 Appeals in some cases.

- If your problem is about a service covered by Medicare, your benefits for that service will **not** continue during the Level 2 Appeal with the Independent Review Entity.
- If your problem is about a service covered by Healthy Connections Medicaid (including a service covered by both Medicare and Healthy Connections Medicaid), you can ask that your benefits for that service continue during the Level 2 Appeal with the Division of Appeals and Hearings. You must make the request on or before the later of the following in order to continue your benefits:
  - Within 10 calendar days of the plan's Level 1 Appeal decision; **or**
  - The intended effective date of the action.
- If you meet this deadline, you can keep getting the disputed service while your appeal is processing. If your benefits are continued and the final result of the appeal upholds our action, we may recover the cost of the services provided to you while the appeal was pending.

How will I find out about the decision?

If your Level 2 Appeal went to the Division of Appeals and Hearings, they will send you a letter explaining their decision.

- If the Division of Appeals and Hearings says **Yes** to part or all of what you asked for, we must authorize the coverage within 72 hours.
- If the Division of Appeals and Hearings says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast

appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.

- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I appealed to both the Independent Review Entity and the Division of Appeals and Hearings and they have different decisions?

If either the Independent Review Entity or the Division of Appeals and Hearings decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal went to the Division of Appeals and Hearings, and you do not agree with the hearing officer's decision, you can file an appeal to the Administrative Law Court. You must file this appeal within 30 calendar days of the date you were notified of the decision. There is a fee to appeal.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to Section I on page 47 for more information on additional levels of appeal.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request. If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 13. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision" or "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 47 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Healthy Connections Medicaid, you can file a Level 2 Appeal yourself (refer to Section E4 on page 17).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Healthy Connections Medicaid may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs in Tier 3. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs in Tier 3 follow the process in **Section E** on page 10.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> **The legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?

Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 25. Also refer to Sections F3 and F4 on page 26 and 27.	Skip ahead to **Section F4** on page 27.	Skip ahead to **Section F4** on page 27.	Skip ahead to **Section F5** on page 30.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5, Section B, page 9).

    - The extra rules and restrictions on coverage for certain drugs include:

        - Being required to use the generic version of a drug instead of the brand name drug.

        - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization" (PA).)

        - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")

        - Quantity limits. For some drugs, we limit the amount of the drug you can have.

> **The legal term** for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

F3. Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 30 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-888-978-0862 (TTY 711)**. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D on page 6 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7, Section A, page 2 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function**.

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 48.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

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

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-888-978-0862 (TTY: 711)**.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at the number at the bottom of the page.

At a glance: How to make a Level 1 Appeal

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

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4 on page 27.

> **The legal term** for "fast appeal" is **"expedited redetermination."**

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at the number at the bottom of the page.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
    - If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you when your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights.” If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at the number at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The “Important Message” tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at the number at the bottom of the page. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you.

In South Carolina, the Quality Improvement Organization is called KEPRO. To make an appeal to change your discharge date, call KEPRO at 1-888-317-0751 (TTY: 711).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. “An Important Message from Medicare about Your Rights” contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-317-0751 and ask for a “fast review”.

Call before you leave the hospital and before your planned discharge date.

- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4 on page 38.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at the number at the bottom of the page. You can also call the State Health Insurance Assistance Program (SHIP), known as I-CARE in South Carolina, at 1-800-868-9095. TTY users should call 711. You can also call the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users should call 711.

What is a Quality Improvement Organization?

It is 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. These experts are not part of our plan.

Ask for a “fast review”

You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review” is **“immediate review.”**

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> **The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the number at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can refer to the sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In South Carolina, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at 1-888-317-0751 (TTY: 711).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-317-0751 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

G4. What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we look at all of the information about your hospital stay. We check if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services at the number at the bottom of the page. Ask for a "fast review" of your hospital discharge date. The call is free.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
- It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 48 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge. Please refer to Section I on page 47 for more information about Level 3 Appeals.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the “Notice of Medicare Non-Coverage.” The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying for your care.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 48 tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at the number at the bottom of the page. Or call your State Health Insurance Assistance Program, known as I-CARE in South Carolina, at 1-800-868-9095.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In South Carolina, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at 1-888-317-0751 (TTY: 711). Information about appealing to the Quality Improvement Organization is also in the “Notice of Medicare Non-Coverage.” This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-888-317-0751 and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. These experts are not part of our plan.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 45.

> **The legal term** for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at the number at the bottom of the page 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 refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> **The legal term** for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In South Carolina, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at 1-888-317-0751 (TTY: 711). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-888-317-0751 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services at the number at the bottom of the page. Ask for a “fast review.” The call is free.

We will give you our decision within 72 hours.

- During this review, we look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”

- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.
- It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.
    - If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

> **The legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 48 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.

- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

I. Taking your appeal beyond Level 2

I1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator’s decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Healthy Connections Prime Advocate. The phone number is 1-844-477-4632. TTY users should call 711.

I2. Next steps for Healthy Connections Medicaid services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Healthy Connections Medicaid services or items, and both of your appeals have been turned down, you have the right to additional levels of appeal. If you have questions after your Level 2 Appeal, contact the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users should call 711. This advocate will explain your options and will always act in your best interest.

Level 3 of the appeals process is an Administrative Law Court (ALC) hearing. If you want an ALC hearing, start by completing the "Request for Contested Case Hearing" form available at www.scalc.net/pub/pubRequestForContestedCaseHearing.pdf. You must submit this form within 30 calendar days of the date you were notified of the Level 2 decision. There is a $25 fee to appeal. If you cannot afford the fee, you can file a "Request to Waive Filing Fee." This form can be found at www.scalc.net/pub/pubRequestToWaiveFilingFee.pdf.

If you are appealing a Level 2 decision made by hearing, you will be responsible for the cost of making a transcript of the hearing. A transcript is a written record of the hearing. The cost of the transcript is approximately $16 for each hour that the transcriptionist spends typing the transcript.

The rules for appealing to the ALC are found at www.scalc.net/rules.aspx. If you do not follow the rules, your appeal may be dismissed.

J. How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 51.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- First Choice VIP Care Plus staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, other health professionals, or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

> **The legal term** for a "complaint" is a **"grievance."**
>
> **The legal term** for "making a complaint" is **"filing a grievance."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. For more information about internal complaints, read the next section. For more information about external complaints, read Section J3 on page 51.

If you need help making an internal and/or external complaint, you can call the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users should call 711.

J2. Internal complaints

To make an internal complaint, call Member Services at the number at the bottom of the page. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- You may write to us at the following address:

  First Choice VIP Care Plus
  Attn: Customer Experience, Grievances, and Complaints
  P.O. Box 7140
  London, KY 40742-7140

To make a “fast complaint”, call Member Services at the number at the bottom of the page.

> **The legal term** for “fast complaint” is **“expedited grievance.”**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If 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 to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and explain our reasons. We will respond whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell the Healthy Connections Prime Advocate about your complaint

You can call the Healthy Connections Prime Advocate to tell them about your complaint. They are not connected with us or any insurance company or health plan. The phone number for the Healthy Connections Prime Advocate is 1-844-477-4632. TTY users should call 711. This call is free and so are the services. For more information, you can also visit www.healthyconnectionsprimeadvocate.com.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Office for Civil Rights
U.S. Department of Health & Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Phone: 1-800 368-1019; TTY: 1-800 537-7697
Fax: (202) 619-3818

You may also have rights under the Americans with Disability Act and under state law. You can contact the Healthy Connections Prime Advocate for assistance. The phone number is 1-844-477-4632. TTY users should call 711.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section E, page 9.

In South Carolina, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-888-317-0751 (TTY: 1-855-843-4776).

Chapter 10: Ending your membership in our Medicare-Medicaid Plan

Introduction

This chapter tells you when and how you can end your membership in our plan and what your health coverage options are after you leave our plan. If you leave our plan, you will still be in the Medicare and Healthy Connections Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. When you can end your membership in our Medicare-Medicaid Plan

You can end your membership in First Choice VIP Care Plus Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on October 18, your coverage with our plan will end on October 31. Your new coverage will begin the first day of the next month (November 1, in this example). If you leave our plan, you can get information about your:

- Medicare options in the table on page 4.
- Healthy Connections Medicaid services on page 5.

You can get more information about when you can end your membership by calling:

- South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670.
- State Health Insurance Assistance Program (SHIP), I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711.
- 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.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5, Section G, page 18 for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, tell Healthy Connections Medicaid or Medicare that you want to leave First Choice VIP Care Plus:

- Call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 4.

C. How to join a different Medicare-Medicaid Plan

If you want to keep getting your Medicare and Healthy Connections Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. Tell them you want to leave First Choice VIP Care Plus and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with First Choice VIP Care Plus will end on the last day of the month that we get your request.

D. How to get Medicare and Healthy Connections Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave First Choice VIP Care Plus, you will return to getting your Medicare and Healthy Connections Medicaid services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE)**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. You will automatically be disenrolled from First Choice VIP Care Plus when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. You will automatically be disenrolled from First Choice VIP Care Plus when your Original Medicare and prescription drug plan coverage begins.

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call Insurance Counseling Assistance and Referrals for Elders (I-CARE) at 1-800-868-9095. TTY users should call 711.	**Here is what to do:** 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. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. You will automatically be disenrolled from First Choice VIP Care Plus when your Original Medicare coverage begins.

D2. How to get your Healthy Connections Medicaid services

If you leave our plan, you will get your Healthy Connections Medicaid services through fee-for-service. This is how most people got Medicaid services before they joined First Choice VIP Care Plus.

Your Healthy Connections Medicaid services include most long-term services and supports and behavioral health care.

If you leave our plan, you can use any provider that accepts Healthy Connections Medicaid.

E. Keep getting your medical items, services and drugs through our plan until your membership ends

If you leave First Choice VIP Care Plus, it may take time before your membership ends and your new Medicare and Healthy Connections Medicaid coverage begins. During this time, keep getting your prescription drugs and health care through our plan.

- Use our network providers to receive medical care
- **Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership in First Choice VIP Care Plus ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

These are the cases when First Choice VIP Care Plus must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Healthy Connections Medicaid. Our plan is for people who qualify for both Medicare and Healthy Connections Medicaid.
    - If you no longer qualify for Healthy Connections Medicaid and you believe that an error has been made, call Healthy Connections Medicaid at 1-888-549-0820 (TTY: 1-888-842-3620), Monday through Friday from 8:00 a.m. to 6:00 p.m.
    - If you no longer qualify for Medicare and you believe that an error has been made, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048). Calls to this number are free, 24 hours a day, 7 days a week.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you enter a nursing home or skilled nursing facility outside the plan's service area and live there for more than six months.
- If you go to jail or prison for a criminal offense.

- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Healthy Connections Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week. You should also call the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users should call 711.

H. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9, Section J, page 48 for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at the number at the bottom of the page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in First Choice VIP Care Plus. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Healthy Connections Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Healthy Connections Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex or sexual orientation. In addition, we don't discriminate or treat you differently because of your behavior, mental ability, receipt of health care, sexual orientation, or use of services.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights. You can call The South Carolina Human Affairs Commission at 1-800-521-0725. This call is free.

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Chapter 12: Definitions of important words

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing their teeth.

Aid paid pending: You can continue getting previously approved services while you are waiting for a decision about a Level 1 Appeal (and for a Healthy Connections Medicaid service, while you are waiting for a decision about a Level 2 Appeal). This continued coverage is called "aid paid pending." Please refer to Chapter 9 to learn more. Please call Member Services at the number at the bottom of the page if you have other questions.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar: A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. [*Insert if the formulary includes interchangeable biosimilars:* Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan for what health services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. You are an important member of the care team and can also include other family members or friends.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section F, page 10 explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

Comprehensive assessment: A review aimed at getting a deeper look at your medical needs, social needs, and capabilities. We will get information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified and trained health professionals, such as nurses, social workers, and care coordinators.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coordinated and Integrated Care Organization (CICO): Another name for a Medicare-Medicaid Plan.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Cultural competence training: Training that provides additional instruction for health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three tiers.

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

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Healthy Connections Medicaid: South Carolina’s Medicaid program. For more information, refer to the definition of “Medicaid” below.

Healthy Connections Prime: A demonstration program jointly run by South Carolina and the federal government to provide better health care for people who have both Medicare and Healthy Connections Medicaid.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- A member who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- First Choice VIP Care Plus must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider bills you more than the plan's cost sharing amount for services. Show your First Choice VIP Care Plus Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

Because First Choice VIP Care Plus pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Independent Review Entity (IRE): An organization that is hired by the Centers for Medicare & Medicaid Services (CMS) to conduct a Level 2 appeal review for a service or item that is covered by Medicare-only or by both Medicare and Healthy Connections Medicaid. If First Choice VIP Care Plus denies approval for such a service or item during a member's Level 1 appeal, the denied appeal is sent to the IRE to conduct a Level 2 review. The IRE is not connected to First Choice VIP Care Plus and is not a government agency. Please refer to Chapter 9, Section E4, page 17 for more information about Level 2 appeals.

Initial health screen: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

List of Covered Drugs **(Drug List):** A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): Refer to "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to Chapter 2, Section G, page 11 for information about how to contact Medicaid in your state.

Medically necessary:

- Services that are reasonable and necessary:
  - For the diagnosis or treatment of your illness or injury; **or**
  - To improve the functioning of a malformed body member; **or**
  - Otherwise medically necessary under Medicare law.
  - This includes care that keeps you from going into a hospital or nursing home.
- In accordance with Healthy Connections Medicaid law and regulation, services are medically necessary if they are:
  - Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity; **and**
  - Provided at an appropriate facility at the appropriate level of care for the treatment of your medical condition; **and**
  - Provided in accordance with generally 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). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plan,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Healthy Connections Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Healthy Connections Medicaid. First Choice VIP Care Plus includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Healthy Connections Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Healthy Connections Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2, Section A, page 2 and the bottom of the page for information about how to contact Member Services.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics,

and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman (Healthy Connections Prime Advocate): An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. The Healthy Connections Prime Advocate is the ombudsman for people enrolled in Healthy Connections Prime. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook, including information on how to contact the Healthy Connections Prime Advocate.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3, Section D, page 6 explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to First Choice VIP Care Plus's Notice of Privacy Practices for more information about how First Choice VIP Care Plus protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3, Section D, page 6 for information about getting care from primary care providers.

Prior authorization (PA): An approval from First Choice VIP Care Plus you must get before you can get a specific service or drug or use an out-of-network provider. First Choice VIP Care Plus may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets PA from our plan.

- Covered services that need our plan's PA are marked in the Benefits Chart in Chapter 4, Section D.

Some drugs are covered only if you get PA from us.

- Covered drugs that need PA are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial

limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. Refer to Chapter 2, Section E, page 9 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don't get approval, First Choice VIP Care Plus may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4, Section D to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get First Choice VIP Care Plus.

Skilled nursing facility (SNF): A nursing home with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The South Carolina Department of Health and Human Services (SCDHHS) is designated as the single state agency for the administration of the Medicaid program (called "Healthy Connections Medicaid") in South Carolina. SCDHHS is a cabinet-level agency under the Governor of the State of South Carolina.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Tier: A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

First Choice VIP Care Plus Member Services

CALL	1-888-978-0862. This call is free. Seven days a week, 8 a.m. to 8 p.m. After regular business hours, the interactive voice response system will allow you to leave a message for your care coordinator. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. Seven days a week, 8 a.m. to 8 p.m.
WRITE	First Choice VIP Care Plus PO BOX 7107 London, KY 40742-7107
WEBSITE	www.firstchoicevipcareplus.com

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