AmeriHealth Caritas VIP Care Plus, Medicare-Medicaid Plan: **Summary of Benefits 2023**

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Introduction

This document is a brief summary of the benefits and services covered by AmeriHealth Caritas VIP Care Plus. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of AmeriHealth Caritas 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. Disclaimers

This is a summary of health services covered by AmeriHealth Caritas VIP Care Plus for 2023. This is only a summary. Please read the *Member Handbook* for the full list of benefits. An up-to-date copy of the 2023 *Member Handbook* is always available on our website at **www.amerihealthcaritasvipcareplus.com**. You may also call Member Services at **1-888-667-0318 (TTY 711)** to ask us to mail you a 2023 *Member Handbook*.

- AmeriHealth Caritas VIP Care Plus is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.
- Under AmeriHealth Caritas VIP Care Plus you can get your Medicare and Michigan Medicaid services in one health plan. A Care Coordinator will help manage your health care needs.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the *Member Handbook*.
  - **ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-667-0318 (TTY 711) de 8 a.m. a 8 p.m., los siete días de la semana. La llamada es gratuita.**
  - تنويه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية لك مجانًا. يُرجى الاتصال بالرقم **1-888-667-0318 (TTY 711)**، من 8 صباحًا إلى 8 مساءً، سبعة أيام في الأسبوع. المكالمة مجانية.
- **You can also get this document for free in other formats, such as large print, braille, or audio. Call 1-888-667-0318 (TTY 711), 8 a.m. – 8 p.m., seven days a week. The call is free.**

- You can make a request to get this document, now and in the future, in a language other than English or in another format simply by calling Member Services at **1-888-667-0318 (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 this requested language or 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.

B. Frequently Asked Questions

The following chart lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicare-Medicaid Plan?	A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Michigan Medicaid. A Medicare-Medicaid Plan is 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.
What is a Care Coordinator?	A Care Coordinator is a health professional who will help you get care and services that affect your health and wellbeing. You are assigned a Care Coordinator when you enroll with AmeriHealth Caritas VIP Care Plus. 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. **Your Care Coordinator is your "go-to" person** for AmeriHealth Caritas VIP Care Plus. Our goal in AmeriHealth Caritas 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.

Frequently Asked Questions (FAQ)	Answers
What are long term supports and services?	Long term supports and services are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital.
Will I get the same Medicare and Michigan Medicaid benefits in AmeriHealth Caritas VIP Care Plus that I get now?	You will get your covered Medicare and Michigan Medicaid benefits directly from AmeriHealth Caritas VIP Care Plus. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. If you are currently getting services for mental health, substance use, or intellectual/developmental disability needs, you will continue to get these services the same way you do now. When you enroll in AmeriHealth Caritas VIP Care Plus, you and your care team will work together to develop an Individual Integrated Care and Supports Plan (IICSP) to address your health and support needs. You can keep using your doctors and getting your current services for up to 90 days, or 180 days depending on the service, while your IICSP is being completed. When you join our plan, if you are taking any Medicare Part D prescription drugs that AmeriHealth Caritas VIP Care Plus does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for AmeriHealth Caritas VIP Care Plus to cover your drug, if medically necessary.

Frequently Asked Questions (FAQ)	Answers
Can I use the same doctors I use now?	Often that is the case. If your providers (including doctors, therapists, and pharmacies) work with AmeriHealth Caritas VIP Care Plus and have a contract with us, you can keep using them. • Providers with an agreement with us are "in-network." **You must use the providers in AmeriHealth Caritas VIP Care Plus's network.** • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of AmeriHealth Caritas VIP Care Plus's plan. To find out if your doctors are in the plan's network, call Member Services or read AmeriHealth Caritas VIP Care Plus's *Provider and Pharmacy Directory* on the plan's website at www.amerihealthcaritasvipcareplus.com. If AmeriHealth Caritas VIP Care Plus is new for you, you can continue using the doctors you use now while your IICSP is being developed.
What happens if I need a service but no one in AmeriHealth Caritas VIP Care Plus's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, AmeriHealth Caritas VIP Care Plus will pay for the cost of an out-of-network provider.
Where is AmeriHealth Caritas VIP Care Plus available?	The service area for this plan includes: Macomb and Wayne Counties, Michigan. You must live in one of these areas to join the plan.

Frequently Asked Questions (FAQ)	Answers
Do I pay a monthly amount (also called a premium) under AmeriHealth Caritas VIP Care Plus?	You will not pay any monthly premiums to AmeriHealth Caritas VIP Care Plus for your health coverage. (You will be required to keep paying any monthly Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.)
What is prior authorization (PA)?	PA means that you must get approval from AmeriHealth Caritas VIP Care Plus before you can get a specific service or drug or use an out-of-network provider. AmeriHealth Caritas VIP Care Plus may not cover the service or drug if you don't get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. Refer to Chapter 3 of the *Member Handbook* to learn more about PA. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a PA.
What is a referral?	A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. If you don't get approval, AmeriHealth Caritas VIP Care Plus may not cover the services. You don't need a referral for certain specialists, such as women's health specialists. Refer to Chapter 3 of the *Member Handbook* to learn more about when you will need to get a referral from your PCP.

Frequently Asked Questions (FAQ)	Answers
Whom should I contact if I have questions or need help? (continued on the next page)	**If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call your Care Coordinator or AmeriHealth Caritas VIP Care Plus Member Services:** **CALL** **1-888-667-0318** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. After regular business hours, you may obtain plan information from the interactive voice response system and may leave a message for your care coordinator. Member Services also has free language interpreter services available for people who do not speak English. **TTY** **711** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week.
	If you have questions about your health, please call the 24 Hour Nurse Advice line: **CALL** **1-855-843-1145** Calls to this number are free. 24 hours, seven days a week. **TTY** **711** Calls to this number are free. 24 hours, seven days a week.

Frequently Asked Questions (FAQ)	Answers
Whom should I contact if I have questions or need help? (continued on the next page)	**If you have questions about behavioral health services and resources, please call the PIHP General Information Line. If you need immediate behavioral health services, please call the Behavioral Health Crisis Line for the local Prepaid Inpatient Health Plan (PIHP).** **CALL** **PIHP General Information Line for Macomb County** **1-855-996-2264** Calls to this number are free. 8:00 a.m. to 4:45 p.m., Monday through Friday. **TTY** **711** **CALL** **PIHP General Information Line for Wayne County** **1-313-833-2500** Calls to this number are free. 8:00 a.m. -4:30 p.m., Monday through Friday. **TTY** **1-800-630-1044** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Calls to this number are free, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Frequently Asked Questions (FAQ)	Answers
Whom should I contact if I have questions or need help? (continued from previous page)	**CALL** **Behavioral Health Crisis Line for Macomb County** **1-855-927-4747** Calls to this number are free. 24 hours a day, seven days a week. **TTY** **711** Calls to this number are free. 24 hours a day, seven days a week. **CALL** **Behavioral Health Crisis Line for Wayne County** **1-800-241-4949** Calls to this number are free. 24 hours a day, seven days a week. **TTY** **1-800-630-1044** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Calls to this number are free. 24 hours a day, seven days a week.

C. Overview of Services

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

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor	Visits to treat an injury or illness	$0	
	Wellness visits, such as a physical	$0	
	Transportation to a doctor's office	$0	Unlimited round trip Non-Emergency Medical Transportation (NEMT) is covered. In cases where NEMT is only needed to get to an appointment or return home from an appointment, one-way authorization may be provided. Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, and attendants. Prior authorization is required for trips that exceed 50 miles for a one-way ride.
	Specialist care	$0	
	Care to keep you from getting sick, such as flu shots	$0	
	"Welcome to Medicare" preventive visit (one time only)	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests	Lab tests, such as blood work	$0	Prior authorization is required. Not all lab services require prior authorization. Have your provider call the plan to confirm whether an authorization is required.
	X-rays or other pictures, such as CAT scans	$0	Prior authorization is required for some specialized x-ray services. Not all outpatient diagnostic/ therapeutic/ radiological and x-ray services will require authorization. Have your provider call the plan to confirm if an authorization is required.
	Screening tests, such as tests to check for cancer	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (This service is continued on the next page)	Generic drugs (no brand name)	$0 copay for a 30-day supply.	There may be limitations on the types of drugs covered. Please refer to AmeriHealth Caritas VIP Care Plus's *List of Covered Drugs* (Drug List) for more information. Extended-day (up to a 100-day) supply is available at retail pharmacy locations. Mail order pharmacy only allows a 100-day supply of medication. The cost-sharing amount for these extended-day supplies is the same as for a one-month supply ($0).
	Brand name drugs	$0 copay for a 30-day supply.	There may be limitations on the types of drugs covered. Please refer to AmeriHealth Caritas VIP Care Plus's *List of Covered Drugs* (Drug List) for more information. Extended-day supply (up to a 100-day) is available at retail pharmacy locations. Mail order pharmacy only allows a 100-day supply of medication. The cost-sharing amount for these extended-day supplies is the same as for a one-month supply ($0).

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Over-the-counter drugs	$0	There may be limitations on the types of drugs covered. Please refer to AmeriHealth Caritas VIP Care Plus's *List of Covered Drugs* (Drug List) for more information. Up to $75 per quarter may be spent for over-the-counter items included in the OTC catalog and/or online ordering portal. Members may order up to 6 products per category per quarter. There is no limit on the total number of items a member may purchase. OTC catalog and online ordering portal orders are limited to 3 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.
	Medicare Part B prescription drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs. Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization required.
You need emergency care	Emergency room services	$0	Emergency room services are covered in-network, out-of-network (OON), and without prior authorization requirements.
	Ambulance services	$0	Non-emergency ambulance requests between an acute and a sub-acute facility do not require a prior authorization. Prior authorization is required for all other non-emergency ambulance services.
	Urgent care	$0	Urgent care services are covered in-network, out-of-network (OON), and without prior authorization requirements.
You need hospital care	Hospital stay	$0	Prior authorization is required.
	Doctor or surgeon care	$0	Prior authorization is required for inpatient and outpatient.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting better or have special health needs	Rehabilitation services	$0	Prior authorization is required for cardiac and pulmonary rehabilitation services.
	Medical equipment for home care	$0	Prior authorization required.
	Skilled nursing care	$0	Prior authorization required.
You need eye care	Eye exams	$0	Routine examinations are covered once every two years.
	Glasses	$0	The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions. A prior authorization will be required for contact lenses and glasses under some circumstances. Have your provider contact AmeriHealth Caritas VIP Care Plus to see if an authorization is required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care	Dental check-ups, exams, x-rays, cleanings, fillings, tooth extractions, dentures and partial dentures	$0	• Exams and evaluations are covered once every six months. • Cleaning is a covered benefit once every six months. » Bitewing X-rays are a covered benefit only once in a 12-month period. » A panoramic X-ray is a covered benefit once every five years. » A full mouth or complete series of X-rays is a covered benefit once every five years. • Fillings. • Tooth extractions. • Complete or partial dentures are covered once every five years. • Root canals and crowns are not covered.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/auditory services	Hearing screenings	$0	Prior authorization required. Referral required.
	Hearing aid evaluation and fitting	$0	For adults aged 21 and older, the plan covers two fitting/evaluations for hearing aids every year. Prior authorization required. Referral required.
	Hearing aids	$0	For adults aged 21 and older, hearing aids are covered once every five (5) years. Prior authorization required. Referral required.
You have a chronic condition, such as diabetes or heart disease	Services to help manage your disease	$0	Prior authorization required.
	Diabetes supplies and services	$0	Non-preferred brands will require an authorization from the health plan.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition	Behavioral health services	$0	Provided through the Prepaid Inpatient Health Plan (PIHP) The PIHP must approve admission for mental health specialty services, non-physician. Prior authorization is required.
You have concerns related to substance use	Substance use services	$0	Provided through the Prepaid Inpatient Health Plan (PIHP) The PIHP must approve admission for outpatient substance abuse services. Prior authorization is required.
You need durable medical equipment (DME) (This services is continued on the next page)	Wheelchairs	$0	Authorization is required for Medicare-covered DME items over $500 for purchase. Authorization is required for all Medicare-covered DME rental items. Prior authorization is required for Medicaid covered DME items. Enteral nutrition requires authorization.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) (This services is continued on the next page)	Nebulizers	$0	Authorization is required for Medicare-covered DME items over $500 for purchase. Authorization is required for all Medicare-covered DME rental items. Prior authorization is required for Medicaid covered DME items.
	Crutches	$0	Authorization is required for Medicare-covered DME items over $500 for purchase. Authorization is required for all Medicare-covered DME rental items. Prior authorization is required for Medicaid covered DME items.
	Walkers	$0	Authorization is required for Medicare-covered DME items over $500 for purchase. Authorization is required for all Medicare-covered DME rental items. Prior authorization is required for Medicaid-covered DME items.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) (continued)	Oxygen equipment and supplies	$0	Authorization is required for Medicare-covered DME items over $500 for purchase. Authorization is required for all Medicare-covered DME rental items. Prior authorization is required for Medicaid-covered DME items.
You need help living at home (This service is continued on the next page)	Meals brought to your home	$0	Limited to two meals per day. This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (This service is continued on the next page)	Chore services, such as heavy household chores and mowing and raking	$0	This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Prior authorization required.
	Preventive nursing services	$0	Limited to no more than two hours per visit. This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Enrollees receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services. Prior authorization required.
	Private duty nursing services to provide skilled nursing services in your home	$0	Limited to 16 hours per day. This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Prior authorization required. Referral required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (This service is continued on the next page)	Fiscal intermediary services to help you control your budget and choose the staff to work with you	$0	This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Providers of other services to the enrollee, his or her family or guardians may not provide Fiscal Intermediary service to the enrollee. Prior authorization required.
	Environmental modifications to your home, such as adding ramps and widening doorways	$0	This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Prior authorization required.
	Expanded community living supports to help you complete activities of daily living and instrumental activities of daily living	$0	This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Prior authorization required.
	Personal care services (You may be able to choose your own personal care assistant. Call Member Services for more information.)	$0	Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (This service is continued on the next page)	Personal Emergency Response System (PERS)	$0	Prior authorization required.
	Assistive technology	$0	This benefit can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. The maximum plan benefit coverage amount is $5000/year. Prior authorization required.
	Home health care services	$0	Medicaid home health services must be ordered, in writing, by your physician as part of a written plan of care (POC) and reviewed by this physician every 60 days. Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	Adult day services or other support services	$0	Adult day program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the plan of care, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the enrollee. Prior authorization required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Nursing home care	A Patient Pay Amount (PPA) may be required.	Services are only available to individuals who meet the Michigan Medicaid Nursing Facility Level of Care Determination standards. A physician order and complete PASRR screen is required for nursing home admission. Prior authorization required
Your caregiver needs some time off	Respite care	$0	General respite services are limited to 336 hours per every 365 day period. Respite waiver services can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization. Prior authorization required
Additional covered services	Fitness benefit	$0	SilverSneakers® is a fitness benefit which includes access to participating SilverSneakers® fitness facilities, online wellness resources, and classes, at no additional cost.

D. Services covered outside of AmeriHealth Caritas VIP Care Plus

This is not a complete list. Call your Care Coordinator or Member Services to find out about other services not covered by AmeriHealth Caritas VIP Care Plus but available through Medicare or Michigan Medicaid.

Other services covered by Medicare or Michigan Medicaid	Your costs
Prepaid Inpatient Health Plan (PIHP) services: Inpatient behavioral health care, outpatient substance use disorder services, and partial hospitalization services	$0
Some hospice care services	$0

E. Services that AmeriHealth Caritas VIP Care Plus, Medicare, and Michigan Medicaid do not cover

This is not a complete list. Call your Care Coordinator or Member Services to find out about other excluded services.

Services not covered by AmeriHealth Caritas VIP Care Plus, Medicare, or Michigan Medicaid
Chiropractic care other than the 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.
Elective abortions and related services.
Experimental medical and surgical treatments, items, and drugs unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Experimental treatment and items are those that are not generally accepted by the medical community.
Naturopath services (the use of natural or alternative services).
Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.

Services not covered by AmeriHealth Caritas VIP Care Plus, Medicare, or Michigan Medicaid
Personal items in your room at a hospital or nursing facility, such as a telephone or television.
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.
Private room in a hospital or nursing facility, except when it is medically necessary.
Vision procedures such as radial keratotomy and LASIK surgery.
Reversal of sterilization procedure, sex change operations, and non-prescription contraceptive supplies.
Routine foot care, except for the limited coverage provided according to Medicare guidelines.
Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.

F. Your rights as a member of the plan

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

- **You have a right to respect, fairness and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
  - Get information in other formats (e.g., large print, braille, audio)
  - Be free from any form of physical restraint or seclusion
  - Not be billed by network providers
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a format you can understand. These rights include getting information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and care managers
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a Primary Care Provider (PCP) and change your PCP at any time during the year
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered
  - Refuse treatment, even if your doctor advises against it
  - Stop taking medicine

  - Ask for a second opinion. AmeriHealth Caritas VIP Care Plus will pay for the cost of your second opinion visit.

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

For more information about your rights, you can read the AmeriHealth Caritas VIP Care Plus *Member Handbook*. If you have questions, you can also call AmeriHealth Caritas VIP Care Plus Member Services.

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

If you have a complaint or think AmeriHealth Caritas VIP Care Plus should cover something we denied, call AmeriHealth Caritas VIP Care Plus at the number at the bottom of the page. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the AmeriHealth Caritas VIP Care Plus *Member Handbook*. You can also call AmeriHealth Caritas VIP Care Plus Member Services.

If you would like to contact AmeriHealth Caritas VIP Care Plus about a compliant, grievance, or appeal, mail or call us at:

AmeriHealth Caritas VIP Care Plus
Attn: Appeals and Grievances Department
P.O. Box 80109
London, KY 40742-0109

Phone number: **1-888-667-0318 (TTY 711)**, seven days a week, 8 a.m. to 8 p.m.

H. What do you do if you suspect fraud

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

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

- Call us at AmeriHealth Caritas VIP Care Plus Member Services. Phone numbers are on the cover of this summary.
- Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, contact the Michigan Attorney General's Health Care Fraud Division Hotline by phone at **(800) 24-ABUSE [800-242-2873]**, by e-mail at hcf@michigan.gov or use the on-line Michigan Medicaid Fraud Complaint Form found at secure.ag.state.mi.us/complaints/medicaid.aspx**.**

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