Health CHOICE GENERATIONS

Health Choice Generations (HMO D-SNP)

2020 SUMMARY OF BENEFITS

ARIZONA

Serving Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties.

Health Choice Generations (HMO D-SNP)

SUMMARY OF BENEFITS

January 1, 2020 – December 31, 2020

ABOUT HEALTH CHOICE GENERATIONS (HMO D-SNP)

HOW TO REACH US:

You can call us 7 days a week, 8:00 a.m. to 8:00 p.m.
If you are a Member of this plan, call toll-free:
(800) 656-8991; TTY 711
If you are not a Member of this plan, call toll-free:
(855) 243-3935; TTY 711
Or visit our website:
www.HealthChoiceGenAZ.com

Health Choice Generations has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory on our website www.HealthChoiceGenAZ.com or call us and we will send you a copy of the provider and pharmacy directories.

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You may access our EOC on our website at www.HealthChoiceGenAZ.com.

WHO CAN JOIN?

To join Health Choice Generations, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Arizona Health Care Cost Containment System (AHCCCS) and live in our service area. Our service area includes the following counties in Arizona: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal and Yavapai.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website www.HealthChoiceGenAZ.com or call us and we will send you a copy of the formulary.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

Health Choice Generations has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider directory, pharmacy directory and formulary on our website: www.HealthChoiceGenAZ.com or you can call us and we will send you a copy of the provider and pharmacy directories, and/or formulary.

Note: The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS:

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan, such as Health Choice Generations.

YOU HAVE CHOICES. TIPS FOR COMPARING MEDICARE PLANS.

This Summary of Benefits booklet gives you a summary of what Health Choice Generations covers and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklet or use the Medicare Plan Finder on http://www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 800-MEDICARE (1-800- 633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

Health Choice Generations HMO D-SNP is a Health Plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Health Choice Generations HMO D-SNP depends on contract renewal.

This information is available in other formats, such as Braille, large print, and audio.

This information is not a complete description of benefits. Call (800) 656-8991; TTY 711 for more information.

HEALTH CHOICE GENERATIONS 2020 SUMMARY OF BENEFITS CHART

Cost sharing for Medicare Covered benefits in the chart below are based on your level of AHCCCS (Medicaid) Eligibility. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.

MONTHLY PREMIUM, DEDUCTIBLES AND LIMITS	
Monthly Health Plan Premium	$0 - $28.10 based on your level of Medicaid eligibility.
Deductible	$0 or $198 based on your level of Medicaid eligibility. $0 or $89 per year for Part D prescription drugs. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	If you lose your AHCCCS eligibility, the yearly maximum you will ever pay in Health Choice Generations (your maximum out-of-pocket amount) is $6,700. If this occurs and you pay the full maximum out-of-pocket amount, we will pay for all part A and B services for the rest of the year.

COVERED MEDICAL AND HOSPITAL BENEFITS	
INPATIENT HOSPITAL COVERAGE	
Prior Authorization may be required	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Depending on your level of AHCCCS (Medicaid) eligibility, you may pay: $1,408 deductible for each benefit period Days 1-60: $0 coinsurance for each benefit period Days 61-90: $352 coinsurance per day of each benefit period Days 91 and beyond: $704 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.

COVERED MEDICAL AND HOSPITAL BENEFITS	
OUTPATIENT HOSPITAL COVERAGE	
Outpatient Hospital Prior Authorization may be required	$0 copay or 20% of the cost
Outpatient Hospital Observation Services Prior Authorization may be required	$0 copay or 20% of the cost
Ambulatory Surgery Center	$0 copay or 20% of the cost
DOCTOR VISITS	
Primary Care	$0 copay or 20% of the cost
Specialists	$0 copay or 20% of the cost
PREVENTIVE CARE	
Alcohol misuse screenings & counseling	$0 copay
Annual wellness visit	
Bone mass measurements (bone density)	
Cardiovascular disease screening tests	
Colorectal cancer screening	
Counseling to Prevent Tobacco Use	
Depression screenings	
Diabetes screenings	
Diabetes self-management training	
Glaucoma screening	
Hepatitis B Virus Screening	
Hepatitis B Virus Vaccine and Administration	
Hepatitis C Virus screening test	
Human Immunodeficiency Virus (HIV) screening	
Influenza Virus Vaccine and Administration	
Initial Preventive Physical Examination (IPPE)	
Intensive Behavioral Therapy for Cardiovascular Disease	
Intensive Behavioral Therapy for Obesity	
Lung cancer screening counseling and annual screening for Lung Cancer with low dose computed tomography	
Medical Nutrition Therapy	
Pneumococcal Vaccine and Administration	
Prostate Cancer Screening	
Screening for Cervical Cancer with Human Papillomavirus tests	
Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling to Prevent STIs	
Prolonged Preventive Services	

COVERED MEDICAL AND HOSPITAL BENEFITS	
PREVENTIVE CARE	
Screening Mammography **Screening Pap Tests** **Screening Pelvic Examinations** (includes a clinical breast examination) **Ultrasound Screening for Abdominal Aortic Aneurysm**	$0 copay
EMERGENCY CARE	
Emergency Care	$0 copay or 20% of the cost up to $90 for Medicare-covered emergency room visits.
URGENTLY NEEDED SERVICES	
Urgent Care	$0 copay or 20% of the cost up to $65 for Medicare-covered urgently needed services.
DIAGNOSTIC SERVICES/LABS/IMAGING LAB SERVICES	
Diagnostic tests and procedures Prior authorization may be required	$0 copay or 20% of the cost
Lab Services Prior authorization may be required	$0 copay
Diagnostic radiology (e.g., MRI, CT) Prior authorization may be required	$0 copay or 20% of the cost
Outpatient x-rays	$0 copay or 20% of the cost
Therapeutic radiology Prior authorization may be required	$0 copay or 20% of the cost
HEARING SERVICES	
Medicare covered diagnostic hearing and balance exams. *They're covered only when your doctor or other health care provider orders them to see if you need medical treatment.*	$0 copay or 20% of the cost
Routine Hearing Exam (Supplemental Benefit)	$0 copay One Exam per year
Hearing Aid Fitting and Hearing Aid (Supplemental Benefit)	$0 copay Maximum plan benefit amount of $1500 per ear every 3 years for hearing aid and fitting.

COVERED MEDICAL AND HOSPITAL BENEFITS

DENTAL SERVICES

Medicare-covered dental services Medicare Part A (Hospital Insurance) will pay for certain dental services that you get when you're in a hospital. Part A can pay for in-patient hospital care if you need to have emergency or complicated dental procedures, even though the dental care isn't covered.	$0 copay or 20% of the cost
Preventive and Comprehensive Dental (Supplemental Benefit) **Preventive:** Two Oral Exams per year, one every six months. One Fluoride Treatment per year. Two Prophylaxis (Cleanings) per year, one every six months. Two x-rays per year, which can consist of: One of either bitewing x-rays or single x-rays OR One complete aka full mouth (fmx) aka panoramic set. Complete/ panoramic only allowed once every 36 months. Exam and cleaning must be performed in the same preventive office visit. X-ray must be taken during a preventive office visit. **Comprehensive:** Including non-routine diagnostic, restorative, and endodontics/ periodontics/extractions services. Dentures covered once every 5 years. Adjustments up to 4 per year. Prior authorization required for Dentures.	$0 copay $3,000 plan coverage limit per calendar year for all dental services combined.

VISION SERVICES

Medicare-covered vision exam to diagnose/ treat diseases of the eye (including yearly glaucoma screening) **Eyeglasses or contact lenses after cataract surgery**	$0 copay or 20% of the cost
Routine Eye Exam (Supplemental Benefit)	$0 copay One every year.
Eyewear (Supplemental Benefit) • Contact Lenses • Eyeglasses (frames and lenses)	$0 copay Our plan pays up to $300 every year for eyewear

COVERED MEDICAL AND HOSPITAL BENEFITS

MENTAL HEALTH SERVICES

Inpatient Hospital Psychiatric Prior authorization may be required	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Depending on your level of Medicaid eligibility, you may pay: • $1,408 deductible for each benefit period • Days 1-60: $0 coinsurance for each benefit period • Days 61-90: $352 coinsurance per day of each benefit period • Days 91 and beyond: $704 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs
Outpatient Individual/ Group Therapy Visit • Mental Health Specialty Service • Psychiatric Services • Substance Abuse	$0 or 20% of the cost

COVERED MEDICAL AND HOSPITAL BENEFITS

SKILLED NURSING FACILITY

Prior Authorization may be required	Our plan covers up to 100 days in a SNF. Depending on your level of AHCCCS (Medicaid) eligibility, you may pay: Days 1–20: $0 for each benefit period. Days 21–100: $176 coinsurance per day of each benefit period. Days 101 and beyond: all costs. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0.

OUTPATIENT REHABILITATION

Physical Therapy and Speech Therapy Services Prior authorization may be required	$0 copay or 20% of the cost
Cardiac and Pulmonary Rehabilitation Prior authorization may be required	$0 copay or 20% of the cost
Supervised Exercise Therapy (SET) Prior Authorization may be required SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	$0 copay or 20% of the cost
Occupational Therapy Services Prior authorization may be required	$0 copay or 20% of the cost

AMBULANCE

Prior authorization required for non-emergent ambulance only.	$0 copay or 20% coinsurance for ground $0 copay or 20% coinsurance for air

TRANSPORTATION

Covered Services include: • Pick-up to or from plan approved locations, limited to covered supplemental benefits, not covered by Medicaid. • Curb-to-curb service. • Wheelchair-accessible vans upon request. • Each one-way trip must not exceed 50 miles. A trip is considered one way, a round trip is considered two trips. **Covered Services do not include:** • Transportation by ambulance.	$0 copay 24 One-way trips every year to or from approved location

PRESCRIPTION DRUG BENEFITS

MEDICARE PART B DRUGS

Chemotherapy drugs Prior authorization may be required	$0 copay or 20% of the cost
Other Part B drugs Prior authorization may be required	$0 copay or 20% of the cost
Part B Drugs – Step Therapy	Step Therapy is covered for: Part B Drugs to Part B Drugs and Part D Drugs to Part B Drugs

PRESCRIPTION DRUG BENEFITS

MEDICARE PART D DRUGS

Medicare-covered only

There are "drug payment stages" for your Medicare Part D prescription drug coverage under Health Choice Generations. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled:

Initial Coverage stage: During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. Your yearly deductible is $0 or $89. Your cost sharing amounts for drugs are:

	Generic/Treated as generic drugs, per prescription (retail or mail order pharmacy, 1-month or 3-month supply)	**Brand name drugs, per prescription (retail or mail order pharmacy, 1-month or 3-month supply)**
Institutionalized Members	$0	$0
Full Benefit Dual Eligible (FBDE) members up to or 100% FPL	$1.30	$3.90
Full Benefit Dual Eligible (FBDE) members over 100% FPL	$3.60	$8.95
QMB/QMB+/SLMB+ members at or below 135 FPL	$3.60	$8.95
< 150% FPL	15% coinsurance	15% coinsurance

These co-pay amounts are only for in-network pharmacies.

Amounts and stages shown are based on being eligible for the Low Income Subsidy (LIS) aka "Extra Help" if you lose your LIS eligibility your stages and the amount you pay will change to Original Medicare levels.

You may get your drugs at in-network retail and mail order pharmacies.

You may be able to get a 3-month supply of your prescription (if your drug is applicable).

Less than 30 day fills will have a prorated copay based on the number of days filled.

On 1/1/2021 you go back to the Initial Coverage stage.

You generally stay in this stage until the amount of your year-to-date "out-of-pocket costs" reaches $6,350. You then skip directly to the Catastrophic Coverage stage.

Catastrophic Coverage stage: During this stage, Health Choice Generations will pay all of the costs of your drugs until 12/31/2020.

ADDITIONAL COVERED BENEFITS	
SERVICES TO TREAT KIDNEY DISEASE	
• Kidney disease education services • Dialysis Services • Home dialysis equipment and supplies	$0 copay or 20% of the cost
CHIROPRACTIC SERVICES	
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) Prior Authorization may be required	$0 copay or 20% of the cost
HOME HEALTH CARE	
Prior Authorization may be required	$0 copay
OUTPATIENT BLOOD SERVICES	
	$0 copay or 20% of the cost
OPIOID TREATMENT PROGRAM SERVICES (OTPS)	
• FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	$0 copay or 20% of the cost
FOOT CARE (PODIATRY SERVICES)	
Medicare-covered Foot Exam and Treatment Foot exams and treatment if you have diabetes-related nerve damage and/or meet conditions.	$0 copay or 20% of the cost
Routine Foot Care (Supplemental Benefits) Prior authorization may be required	$0 copay 12 visits per year
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen) Prior Authorization may be required	$0 copay or 20% of the cost
Prosthetics/Medical Supplies Prior Authorization may be required	$0 copay or 20% of the cost
Diabetic Supplies and Services Prior Authorization applies to only insulin pumps and not regular supplies (lancet, strips)	$0 copay or 20% of the cost
ADDITIONAL COVERED BENEFITS	
Over-the-Counter (OTC) quarterly purchases for product items are done via the OTC catalog. Shipping is free with quarterly orders.	$0 copay for $150 allowance every 3 months

ADDITIONAL COVERED BENEFITS	
Meal Benefit Prior Authorization may be required	$0 copay for 10 meals per admit, once per calendar year, immediately following an acute inpatient hospital stay.
Fitness Membership The Silver & Fit Exercise & Healthy Aging Program provides members with the following services: • Members receive a fitness center membership. • Available fitness center types include full centers, basic coed centers, YMCAs, gender-specific centers, and exercise centers. • Fitness advisors at Silver & Fit contracted centers will meet with the Silver & Fit members to introduce them to the fitness center and assist them with enrolling at the fitness center. www.silverandfit.com for more information.	$0 Copay
Special Supplemental Benefits for the Chronically Ill If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill. • Coronary artery disease with diabetes • Active Cancer • Kidney failure after transplant Your PCP may request these services for you The Care Manager may assess you and offer these services based on your needs. To improve health outcomes for members with complex health care needs, Health Choice Generations is offering a Special Supplemental Benefit for the Chronically Ill (SSBCI). This benefit will be administered to eligible enrollees requiring intensive care coordination who meet all three conditions below: 1. has one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee; 2. has a high risk of hospitalization or other adverse health outcomes; 3. and requires intensive care coordination.	$0 copay Services include: Assistance in performing activities of daily living • Respite for caregivers • Companionship • Help with bathing and showering • Help with dressing and grooming • Light housekeeping (cleaning, laundry, dishes) • Transportation to errands • Transportation to medical appointments • Meal preparation • Medication reminders In addition, we offer weekly well check calls. All at no cost. Services provided will be based on the need of the individual and a plan of care developed with the member and their family. Total of 8 hours per month (2-hour shifts weekly or 4-hour shifts bi-monthly).
24-Hour Nurse Advice Line 1-855-458-0622 Available 24 hours a day, 7 days a week.	$0 copay

SUMMARY OF MEDICAID-COVERED BENEFITS

Your state Medicaid program can be reached through the office of the Arizona Health Care Cost Containment System (AHCCCS).

A person who is entitled to both Medicare and medical assistance from a State Medicaid plan is referred to as a "dual eligible" beneficiary. As a dual eligible beneficiary your services are paid first by Medicare and then by Medicaid. Your Medicaid coverage varies depending on your income, resources, and other factors. Benefits may include full Medicaid benefits and/or payment of some or all of your Medicare cost-share (premiums, deductibles, coinsurance, or copays). Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Medicare-covered services.

BELOW IS A LIST OF DUAL ELIGIBILITY COVERAGE CATEGORIES FOR BENEFICIARIES WHO MAY ENROLL IN THE HEALTH CHOICE GENERATIONS PLAN:

- ☐ **QMB-plus (or QMB+):** Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You receive Medicaid coverage of Medicare cost-sharing and are eligible for full Medicaid benefits secondary to your Medicare coverage. This means if Medicare doesn't cover something, but Medicaid does, Medicaid will pay (as long as your provider is in-network).
- ☐ **SLMB-plus (or SLMB+):** Medicaid pays your Medicare Part B premium and also provides full Medicaid benefits secondary to your Medicare benefit.
- ☐ **Full-Benefit Dual Eligible (FBDE):** At times, individuals may qualify for both limited coverage of Medicare cost-sharing as well as full Medicaid benefits.

IF YOU ARE A QMB OR QMB-PLUS BENEFICIARY:

You have a $0 cost-share, except for Part D prescription drug copays, as long as you remain a QMB or QMB+ Member.

IF YOU ARE A SLMB-PLUS OR FBDE BENEFICIARY:

You are eligible for full Medicaid benefits and, at times, limited Medicare cost-share. As such your cost-share is 0% or 20%*. Typically your cost-share is 0% when the service is covered by both Medicare and Medicaid. Additionally, preventive wellness exams and supplemental benefits provided by Health Choice Generations are also at a $0 cost-share. In rare instances, you will pay 20%* when a service or benefit is not covered by Medicaid (see the chart below).

Note – Preventive wellness exams and supplemental benefits have a $0 cost-share.

ELIGIBILITY CHANGES:

It is important to read and respond to all mail that comes from Social Security and your state Medicaid office and to maintain your Medicaid eligibility status.

Periodically, as required by CMS, we will check the status of your Medicaid eligibility as well as your dual eligible category. If your eligibility status changes, your cost-share may also change from 0% to 20% or from 20% to 0%. If you lose Medicaid coverage entirely, you will be given a grace period so that you can reapply for Medicaid and become reinstated if you still qualify.

If you no longer qualify for Medicaid you may be involuntarily disenrolled from the Plan. Your state Medicaid agency will send you notification of your

loss of Medicaid or change in Medicaid category. We may also contact you to remind you to reapply for Medicaid. For this reason it is important to let us know whenever your mailing address and/or phone number changes.

If you are currently entitled to receive full or partial Medicaid benefits please see your Medicaid member handbook or other state Medicaid documents for full details on your Medicaid benefits, limitations, restrictions, and exclusions. In your state, the Medicaid program can be reached through the office of the Arizona Health Care Cost Containment System (AHCCCS).

*Annual deductible for Part B services, and 20% coinsurance (as applicable), in addition to varying cost-share amounts for Part A services apply when Member's cost-share amount is not 0%.

HOW TO READ THE MEDICAID BENEFIT CHART

The chart below shows what services are covered by Medicare and Medicaid. You will see the word "Covered" under the Medicaid column if Medicaid also covers a service that is covered under the Health Choice Generations Plan. The chart applies only if you are entitled to benefits under your state's Medicaid program. Your cost-share varies based on your Medicaid category.

MEDICAID-COVERED BENEFITS CHART

	HEALTH CHOICE GENERATIONS	AHCCCS (MEDICAID STATE PLAN)
IMPORTANT INFORMATION		
Premium and Other Important Information If you get Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.	$0 - $28.10	Medicaid assistance with premium payments and cost-share may vary based on your level of Medicaid eligibility.
Doctor and Hospital Choice (For more information, see Emergency Care and Urgently Needed Care.)	In-Network - You must go to network doctors, specialists, and hospitals.	You must go to doctors, specialists, and hospitals that accept Medicaid assignment. Referral required for network specialists for certain benefits.
OUTPATIENT CARE SERVICES		
Acupuncture	Not Covered	Not Covered
Ambulance Services (Medically necessary ambulance services)	Ground and air ambulance transportation service.	Ground and air ambulance transportation services, within certain limitations, for most recipients. See AHCCCS plan for more information.
Chiropractic Services	Covered	AHCCCS (Medicaid) provides additional coverage for some qualified members under 21. If you are under 21, check the AHCCCS website or see AHCCCS plan for more information.

MEDICAID-COVERED BENEFITS CHART		
	HEALTH CHOICE GENERATIONS	**AHCCCS (MEDICAID STATE PLAN)**
OUTPATIENT CARE SERVICES		
Dental Services	Covered	AHCCCS (Medicaid) provides additional coverage for some qualified members. See AHCCCS plan for more information.
Diabetes Programs and Supplies	Covered	Covered See AHCCCS plan for more information.
Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	Covered	Covered See AHCCCS plan for more information.
Doctor Office Visits	Covered	Covered See AHCCCS plan for more information.
Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	Covered	AHCCCS covers reasonable and medically necessary medical equipment, appliances and supplies; orthotic devices and prosthetic devices. See AHCCCS plan for more information.
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	Covered	Covered See AHCCCS plan for more information.
Hearing Services	Covered	AHCCCS (Medicaid) provides additional coverage for qualified members under 21. If you are under 21, check the AHCCCS website or see AHCCCS plan for more information.
Home Health Service (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	Covered	Covered - Covers medically necessary home health services within certain limits. See AHCCCS plan for more information.
Outpatient Mental Health Care	Covered	Covered – Behavioral Health Services

MEDICAID-COVERED BENEFITS CHART		
	HEALTH CHOICE GENERATIONS	**AHCCCS (MEDICAID STATE PLAN)**
OUTPATIENT CARE SERVICES		
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	Covered	Covered See AHCCCS plan for more information.
Outpatient Substance Abuse Care	Covered	Covered See AHCCCS plan for more information.
Over-the-Counter Items	Covered	Not Covered
Podiatry Services	Covered	Covered See AHCCCS plan for more information.
Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	Covered	AHCCCS (Medicaid) provides additional coverage for some qualified members. See AHCCCS plan for more information.
Transportation Services	Covered	Covered trips to the doctor.
Urgently Needed Services	Covered	Covered
Vision Services	Covered	AHCCCS (Medicaid) provides additional coverage for qualified members under 21. If you are under 21, check the AHCCCS website or see AHCCCS plan for more information.
INPATIENT CARE		
Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	Covered	Covered See AHCCCS plan for more information.
Inpatient Mental Health Care	Covered	Covered See AHCCCS plan for more information.
Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	Covered	AHCCCS covers medically necessary nursing facility services. See AHCCCS plan for more information.

MEDICAID-COVERED BENEFITS CHART		
	HEALTH CHOICE GENERATIONS	**AHCCCS (MEDICAID STATE PLAN)**
PREVENTIVE SERVICES		
Kidney Disease and Conditions	Covered	Covered See AHCCCS plan for more information.
Preventive Services including Flu and Pneumonia Vaccines, Screening Mammogram, Pap Smear and Pelvic Exam, Prostate Cancer Screening, and Colorectal Screening.	Covered	Covered See AHCCCS plan for more information.
HOSPICE		
Hospice	Hospice is covered by Original Medicare, outside of our plan. You pay nothing for hospice care from any Medicare approved hospice. You may have to pay part of the costs for drugs and respite care.	Covered See AHCCCS plan for more information.
PRESCRIPTION DRUG BENEFITS		
Outpatient Prescription Drugs	Outpatient Prescription Drugs	Covered See AHCCCS plan for more information.

For Members who are entitled to full benefits under Medicaid, listed below are additional benefits that you may be entitled to. These are additional Medicaid benefits that are covered by your state Medicaid program but may not be covered under the **Health Choice Generations Plan**:

ADDITIONAL MEDICAID BENEFITS	
BENEFITS	**MEDICAID COVERAGE**
Home and Community Based Services	Covered restrictions may apply. Available only for eligible individuals. See AHCCCS plan for more information.
Interpreter Services for Medical Visits	Covered restrictions may apply. See AHCCCS plan for more information.
Long-Term Care Services	Covered restrictions may apply. Available only for eligible individuals. See AHCCCS plan for more information.

NOTICE OF NON-DISCRIMINATION

In Compliance with Section 1557 of the Affordable Care Act

Health Choice Generations (HMO D-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Choice Generations does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Choice Generations:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact:

Health Choice Generations
Address: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Phone: 1-800-656-8991
Fax: 480-760-4739
TTY: 711

If you believe that Health Choice Generations has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email to:

Health Choice Generations
Address: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Phone: 1-800-656-8991
Fax: 480-760-4739
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Grievance Manager/Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This information is available in other formats, such as Braille, large print, and audio.

AVISO DE NO DISCRIMINACIÓN

En cumplimiento con la Sección 1557 de la Ley de Cuidado de Salud de Bajo Costo

Health Choice Generations (HMO D-SNP) cumple con las leyes de derechos civiles federales vigentes y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Health Choice Generations no excluye a las personas ni las trata de manera diferente por su raza, color, nacionalidad, edad, discapacidad o sexo.

Health Choice Generations:

Ofrece material de ayuda y servicios sin cargo a las personas que tienen discapacidades que les impiden comunicarse de manera eficaz con nosotros, como los siguientes:

- Intérpretes de lenguaje de señas calificados
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Brinda servicios de idiomas sin cargo a las personas cuya lengua materna no es el inglés, como los siguientes:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con nosotros:

Health Choice Generations
Dirección: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Teléfono: 1-800-656-8991
Fax: 480-760-4739
TTY: 711

Si considera que Health Choice Generations no ha logrado prestar estos servicios o ha discriminado de algún otro modo a una persona por su raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal por correo, fax o correo electrónico:

Health Choice Generations
Dirección: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Teléfono: 1-800-656-8991
Fax: 480-760-4739
TTY: 711

Puede presentar una queja formal personalmente o por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja formal, el administrador de quejas formales/coordinador de derechos civiles está a su disposición para ayudarlo.

También puede presentar una queja por violación a los derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de forma electrónica a través de su Portal de quejas, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo o teléfono:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Los formularios de queja están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

Esta información está disponible en otros formatos, como braille, letra grande y audio.

MULTI-LANGUAGE INTERPRETER SERVICES

as required by Section 1557 of the Affordable Care Act

Health CHOICE GENERATIONS

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-656-8991 (TTY: 711), 8AM – 8PM, 7 days a week.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia lingüística sin cargo. Llame al 1-800-656-8991 (TTY: 711).

請注意：若您使用繁體中文，您可以接受免費的語言協助服務。請致電 1-800-656-8991 (TTY: 711)。

Bilagáana bizaad doo bee yáníłti' dago dóó saad nááná ła' bee yáníłti'go, saad bee ata' hane', t'áá níík'eh, ná bee ahóót'i' . Kojį' hodíílnih 1-800-656-8991 (TTY: 711).

ATENÇÃO: Se você fala português brasileiro, oferecemos serviços gratuitos de assistência para idiomas. Ligue para 1-800-656-8991 (TTY: 711).

CHÚ Ý: Nếu quý vị nói [Tiếng Việt], chúng tôi sẽ cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hãy gọi số 1-800-656-8991 (TTY: 711).

تنبيه: إذا كنت تتحدث العربية، فسوف تتوفر لديك خدمات المساعدة اللغوية، مجانًا. اتصل على 1-800-656-8991 (هاتف نصي: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-656-8991 (TTY: 711).

ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang, gratis, disponib pou ou. Rele 1-800-656-8991 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Fremdsprachenservice zur Verfügung. Rufen Sie 1-800 -656-8991 (TTY: 711) an.

ΠΡΟΣΟΧΗ: εάν μιλάτε Ελληνικά, μπορείτε να λάβετε δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό 1-800-656-8991 (TTY: 711).

સૂચના: જો તમે બોલતા હોવ, તો તમારા માટે મફત ભાષા સહાયતા સેવાઓ ઉપલબ્ધ છે. સંપર્ક 1-800-656-8991 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। 1-800-656-8991 (TTY: 711) पर कॉल करें।

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiami il numero 1-800-656-8991 (TTY: 711).

MULTI-LANGUAGE INTERPRETER SERVICES

as required by Section 1557 of the Affordable Care Act

Health CHOICE GENERATIONS

注意：日本語を話される場合、無料で言語支援サービスをご利用いただけます。次の番号までお電話してください：1-800-656-8991 (TTY: 711)

주의: 한국어를 사용하는 경우, 언어 지원 서비스가 무료로 제공됩니다. 1-800-656-8991 (TTY: 711) 번으로 전화하십시오.

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើលោកអ្នកនិយាយភាសា ខ្មែរ យើងខ្ញុំមានសេវាកម្មជំនួយភាសាដល់លោកអ្នកដោយមិនគិតថ្លៃនោះទេ។ សូមហៅទូរសព្ទមកលេខ 1-800-656-8991 (TTY៖ 711)។

नेपाली – बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन् । ध्यान दिनुहोस्: तपाईं 1-800-656-8991 (TTY: 711) मा कल गर्नुहोस् ।

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات زبانی رایگان به شما ارائه می‌شود.با 1-800-656-8991 (TTY: 711). تماس بگیرید.

UWAGA: Jeżeli mówi Pan/Pani po polsku, oferujemy bezpłatne usługi pomocy językowej. Prosimy o kontakt pod numerem 1-800-656-8991 (telefon tekstowy (TTY: 711).

ВНИМАНИЕ! Если вы говорите на Русский, вам бесплатно доступны услуги языковой поддержки. Звоните 1-800-656-8991 (телетайп: 711).

PAŽNJA: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su Vam besplatno. Pozovite 1-800-656-8991 (TTY: 711).

ᠰᠡᠯᠪᠡᠭᠡᠨ ᠬᠡᠯᠡᠬᠦ ᠬᠡᠯᠡᠨᠳᠡ ᠲᠠ ᠮᠣᠩᠭᠣᠯ ᠬᠡᠯᠡ ᠶᠠᠷᠢᠵᠤ ᠪᠠᠢᠨ᠎ᠠ ᠤᠤ᠃ ᠲᠠᠨᠳ ᠴᠠᠭᠠᠨ ᠪᠡᠴᠡ ᠬᠡᠯᠡᠨ ᠦ ᠲᠤᠰᠯᠠᠯᠴᠠᠭᠠ ᠦᠵᠦᠯᠬᠡ ᠦᠢᠯᠴᠢᠯᠡᠭᠡᠡ ᠪᠠᠢᠷᠢᠯᠠᠭᠤᠯᠵ ᠪᠣᠯᠣᠨ᠎ᠠ᠃ 1-800-656-8991 (TTY:711) ᠳᠤᠭᠠᠷ ᠬᠣᠯᠪᠣᠭᠤᠷᠠᠵᠤ ᠤᠷᠤᠭᠤᠯᠠᠭᠠᠷᠠᠢ᠃

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-656-8991 (TTY: 711).

Health CHOICE GENERATIONS

MEMBER SERVICES:
1-800-656-8991 | TTY 711
8 a.m. – 8 p.m., 7 days a week

VISIT OUR WEBSITE AT:
www.HealthChoiceGenAZ.com