

2021



AMERICAN HEALTH  
**ADVANTAGE**  
OF MISSOURI

# Summary of Benefits

American Health Advantage of Missouri (HMO I-SNP) H4490 001

January 1, 2021– December 31, 2021

Toll-free: 1-844-228-7934 (TTY/TDD users call 711)

Hours: October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7-days a week

April 1 through September 30, 8:00 a.m. to 8:00 p.m., Monday to Friday

[MO.AmHealthPlans.com](http://MO.AmHealthPlans.com)

**This is a summary of drug and health services covered by  
American Health Advantage of Missouri (HMO I-SNP)  
January 1, 2021 – December 31, 2021**

American Health Advantage of Missouri (HMO I-SNP), offered by Missouri Medicare Select, LLC, is a Health Maintenance Organization (HMO) with a Medicare contract. Enrollment in the American Health Advantage of Missouri depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage” by calling Member Services at 1-844-228-7934 (TTY/TDD users call 711). Hours October 1 through March 31 are 8:00 A.M. to 8:00 P.M. seven (7) days per week; April 1 through September 30 are 8:00 A.M. to 8:00 P.M. Monday to Friday. You may also visit our website at [mo.AmHealthPlans.com](https://mo.AmHealthPlans.com).

To join American Health Advantage of Missouri you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. You must live in one of our network nursing homes. Our service area includes the following Missouri Counties: Bollinger, Boone, Cass, Clay, Cole, Cooper, Crawford, Franklin, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lincoln, Newton, Osage, Pike, Ray, St. Charles, St. Louis, St. Louis City, Ste. Genevieve and Warren.

American Health Advantage of Missouri 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.

| Premiums and Benefits                                                                                     | American Health Advantage of Missouri (HMO I-SNP)                                                                                                                                                                              | What You Should Know                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly Plan Premium                                                                                      | You pay \$30.50                                                                                                                                                                                                                | You must continue to pay your Medicare Part B premium.                                                                                                                                                                                                                                                                                       |
| Deductible                                                                                                | \$198                                                                                                                                                                                                                          | This is the 2020 cost sharing amount and may change for 2021. American Health Advantage of Missouri (HMO I-SNP) will provide the updated rate as soon as they are released.                                                                                                                                                                  |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs)                                | \$7,550 annually                                                                                                                                                                                                               | The most you pay for copays, coinsurance and other costs for medical services in a year.                                                                                                                                                                                                                                                     |
| Inpatient Hospital (including mental health services)                                                     | <p>You pay a \$1,408 deductible each benefit period</p> <p>\$0 copayment for each day for days 1-60</p> <p>\$352 copayment each day for days 61-90</p> <p>\$704 copayment each day for days 91-150 (lifetime reserve days)</p> | <p>These are the 2020 cost sharing amounts and may change for 2021. American Health Advantage of Missouri (HMO I-SNP) will provide updated rates as soon as they are released.</p> <p>Prior authorization is required.</p> <p>Cost sharing is applied starting on the first day of admission and does not include the date of discharge.</p> |
| Outpatient Hospital                                                                                       | 20% of the cost for Medicare-covered services                                                                                                                                                                                  | Prior authorization is required.                                                                                                                                                                                                                                                                                                             |
| Doctor Visits <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Specialist Care</li> </ul> | <p>You pay nothing for Medicare-covered primary care services</p> <p>20% of the cost for Medicare-covered specialist services</p>                                                                                              |                                                                                                                                                                                                                                                                                                                                              |
| Preventive Care (e.g. flu vaccine, diabetic screenings)                                                   | You pay nothing                                                                                                                                                                                                                | Any additional preventive services approved by Medicare during the contract year will be covered.                                                                                                                                                                                                                                            |
| Emergency Care                                                                                            | 20% of the cost for Medicare-covered services up to \$90                                                                                                                                                                       | If you are admitted to the hospital within one (1) day, you do not have to pay \$90.                                                                                                                                                                                                                                                         |

| Premiums and Benefits                                                                                                                                                                                                         | American Health Advantage of Missouri (HMO I-SNP)                                                                                                                                                                                                                               | What You Should Know                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Urgently Needed Services                                                                                                                                                                                                      | 20% of the cost for Medicare-covered services up to \$65                                                                                                                                                                                                                        | If you are admitted to the hospital within three (1) day, you do not have to pay \$65.                                                     |
| Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> <li>• Diagnostic Radiology Services (e.g. MRI)</li> <li>• Lab Services</li> <li>• Diagnostic Tests and Procedures</li> <li>• Outpatient X-Rays</li> </ul> | 20% of the cost for Medicare-covered Diagnostic Radiology Services (e.g. MRI)<br><br>You pay nothing for Medicare-covered lab services<br><br>20% of the cost for Medicare-covered Diagnostic Tests and Procedures<br><br>20% of the cost for Medicare-covered Outpatient X-Ray | Prior authorization is required for some services.                                                                                         |
| Hearing Services<br><br><i>Supplemental Benefit:</i> <ul style="list-style-type: none"> <li>• Routine Hearing Exam</li> <li>• Fitting/Evaluation</li> <li>• Hearing Aids</li> </ul>                                           | 20% of the cost for Medicare-covered services<br><br>\$0 copay Routine Hearing Exam and Fitting/Evaluations                                                                                                                                                                     | One routine Hearing Exam per year.<br><br>Up to \$500 limit, both ears combined per year for Hearing Aids. Must use Plan Approved Provider |
| Dental Services                                                                                                                                                                                                               | 20% of the cost for Medicare-covered services                                                                                                                                                                                                                                   | In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.   |
| Vision Services<br><br><i>Supplemental Benefit:</i> <ul style="list-style-type: none"> <li>• Routine Eye Exam</li> <li>• Eyewear (contact lenses and eyeglasses (lenses and/or frames); upgrades</li> </ul>                   | 20% of the cost for Medicare-covered services<br><br>You pay nothing<br>You pay nothing                                                                                                                                                                                         | One exam per year.<br>Up to \$225 per year.                                                                                                |

| Premiums and Benefits                                                                                                                                | American Health Advantage of Missouri (HMO I-SNP)                                                                                                                                                                                                                                                        | What You Should Know                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mental Health Services <ul style="list-style-type: none"> <li>Outpatient Group Therapy Visit</li> <li>Outpatient Individual Therapy Visit</li> </ul> | 20% of the cost for Medicare-covered services                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                    |
| Skilled Nursing Facility (SNF)                                                                                                                       | Services rendered in member's residence setting:<br>You pay nothing.<br><br>Services rendered outside member's residence setting:<br><br>You pay nothing for the first 20 days of each benefit period.<br><br>You pay \$176 per day for days 21-100*<br><br>You pay all costs for each day after day 100 | This is the 2020 cost sharing amount and may change for 2021. American Health Advantage of Missouri (HMO I-SNP) will provide the updated rate as soon as they are released.<br><br>Prior authorization is required.<br><br>Zero (0) hospital days required prior to SNF admission. |
| Physical Therapy Services                                                                                                                            | 20% of the cost for Medicare-covered Physical Therapy Services                                                                                                                                                                                                                                           | Prior authorization is required.                                                                                                                                                                                                                                                   |
| Ambulance                                                                                                                                            | 20% of the cost for Medicare-covered services                                                                                                                                                                                                                                                            | Prior authorization is required for Medicare-covered non-emergent ambulance transport.                                                                                                                                                                                             |
| <i>Supplemental Benefit:</i><br>Transportation Services (Non-Emergent) <ul style="list-style-type: none"> <li>Van or Medical Transport</li> </ul>    | You pay nothing for up to twenty (20) one-way trips per year to any health-related location                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                    |
| Medicare Part B Drugs                                                                                                                                | 20% of the cost for Medicare covered services                                                                                                                                                                                                                                                            | Prior authorization is required for billed charges in excess of \$250.                                                                                                                                                                                                             |

| <b>Outpatient Prescription Drugs</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
|                                      | <b>Standard Retail Cost-Sharing</b><br>(up to 30-day supply)                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Long-Term Care Cost-Sharing</b><br>(up to 31-day supply) |
| Yearly Deductible<br>(Stage 1)       | \$445 for all Part D prescription drugs <ul style="list-style-type: none"> <li>You begin in this payment stage when you fill first prescription for the year.</li> <li>During this stage, you pay the full cost for your prescription drugs until you have paid \$445.</li> <li>You stay in this stage until you have paid \$445 for your prescription drugs.</li> </ul>                                                                                                                    |                                                             |
| Initial Coverage<br>(Stage 2)        | 25% coinsurance cost-sharing for covered prescription drugs <ul style="list-style-type: none"> <li>During this stage, the Plan pays its share of the cost of your prescription drugs and you pay your share of the cost.</li> <li>You stay in this stage until your year-to-date “total prescription drug costs” (your payments plus any Plan payments) total \$4,130.</li> </ul>                                                                                                           |                                                             |
| Coverage Gap<br>(Stage 3)            | After your drug costs (including what our Plan has paid and what you have paid) reach \$4,130, you pay no more than 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs plus a portion of the dispensing fee <ul style="list-style-type: none"> <li>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$6,550. This amount and rules for counting costs toward this amount have been set by Medicare.</li> </ul> |                                                             |
| Catastrophic Coverage<br>(Stage 4)   | After your yearly out-of-pocket drug costs reach \$6,550 you pay the greater of: <ul style="list-style-type: none"> <li>5% coinsurance; or</li> <li>\$3.70 copayment for generics (including brand drugs treated as generics); or</li> <li>\$9.20 copayment for all other drugs</li> </ul>                                                                                                                                                                                                  |                                                             |

| Other Covered Benefits                                                                                                                                                                                                                                                                                              |                                                                      |                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------|
| Benefits                                                                                                                                                                                                                                                                                                            | American Health Advantage of Missouri (HMO I-SNP)                    | What You Should Know                                                   |
| Occupational Therapy and Speech-Language Therapy                                                                                                                                                                                                                                                                    | 20% of the cost for Medicare-covered services                        | Prior authorization is required.                                       |
| Foot Care (Podiatry Services)<br><br><i>Supplemental Benefit:</i><br>Up to six (6) non-Medicare-covered routine podiatry services per year                                                                                                                                                                          | 20% of the cost for Medicare-covered services<br><br>You pay nothing |                                                                        |
| Medical Equipment/Supplies <ul style="list-style-type: none"> <li>• Durable Medical Equipment (e.g. wheelchairs, oxygen)</li> <li>• Prosthetics (e.g. braces, artificial limbs)</li> <li>• Diabetic Supplies</li> </ul>                                                                                             | 20% of the cost for Medicare-covered services                        | Prior authorization is required for billed charges in excess of \$250. |
| <i>Supplemental Benefit:</i><br>Supervisory Assistance <ul style="list-style-type: none"> <li>• Companion to assist with medical appointments outside of facility</li> <li>• Supervised visits</li> <li>• Assistance with activities of daily living (ADL) and/or comfort when part of supervision visit</li> </ul> | You pay nothing for up to forty (45) hours per calendar year         |                                                                        |

For more information, contact American Health Advantage of Missouri from 8:00 A.M. to 8:00 P.M. October 1<sup>st</sup> through March 31<sup>st</sup>, 7 days a week (April 1<sup>st</sup> through September 30<sup>th</sup> 8:00 A.M. to 8:00 P.M., Monday to Friday) at 1-844-228-7934 (TTY/TDD users call 711) or visit our website at [mo.AmHealthPlans.com](https://mo.AmHealthPlans.com).

You can access the American Health Advantage of Missouri provider or pharmacy directory on our website at [mo.AmHealthPlans.com](https://mo.AmHealthPlans.com) or call Member Services and ask us to send you a provider or pharmacy directory.

For coverage and costs of Original Medicare look in your current “**Medicare & You**” handbook. View it online at [www.medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227) 24 hours per day/7 days per week. TTY users should call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-844-228-7934 (TTY/TDD users call 711) for more information.

You must continue to pay your Medicare Part B premium.

This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.

This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that your condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days.

American Health Advantage of Missouri (HMO I-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2023 based on a review of the American Health Advantage of Missouri Model of Care.

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

Out-of-network/noncontracted providers are under no obligation to treat members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

## **Multi-Language and Non-Discrimination Notice**

American Health Advantage of Missouri (HMO I-SNP), offered by Missouri Medicare Select, LLC. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. American Health Advantage of Missouri does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

American Health Advantage of Missouri:

- 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 American Health Advantage of Missouri Member Services.

If you believe that American Health Advantage of Missouri 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 with: American Health Advantage of Missouri, ATTN: Appeals & Grievances, 201 Jordan Road, Suite 200, Franklin, TN 37067, telephone: 1-844-228-7934 (TTY/TDD users call 711) 8:00 A.M. to 8:00 P.M. seven days a week October 1 through March 31; Monday to Friday April 1 through September 30; fax: 1-844-280-5360; email: [compliance@AmHealthPlans.com](mailto:compliance@AmHealthPlans.com).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, American Health Advantage of Missouri Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of 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 509 F, 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>

#### English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-844-228-7934 (TTY/TDD: 711).

#### Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-228-7934 (TTY/TDD: 711).

#### 繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-228-7934 (TTY : 711)

#### Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-228-7934 (TTY/TDD: 711).

#### Srpsko-hrvatski (Serbo-Croatian)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-228-7934 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

#### Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-228-7934 (TTY/TDD: 711).

#### العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-228-7934 (رقم هاتف الصم والبكم: 117).

#### 한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-228-7934 (TTY/TDD: 711) 번으로 전화해 주십시오.

#### Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-228-7934 (телетайп: 711).

#### Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-228-7934 (ATS : 711).

#### Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-228-7934 (TTY/TDD: 711).

Deutsch (Pennsylvania Dutch)

Wann du schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-228-7934 (TTY/TDD: 711).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم تماس بگیرید. (TTY/TDD: 711). 1-844-228-7934 می باشد. با

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-228-7934 (TTY/TDD: 711).

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-228-7934 (TTY/TDD: 711).

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-844-228-7934 (መስማት ለተሳናቸው: 711)፡



**Toll-free: 1-844-228-7934 (TTY/TDD users call 711)**  
**Hours: October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7-days a week**  
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