



Amerigroup Medicare Advantage Chronic Special Needs Plans 2020

The plans in this guide are available in Pima County, AZ.

Find the plan you want — right here, right now

Use this handy guide to shop smarter for Medicare Advantage plans! For plan details, please check your Summary of Benefits. You can also ask your licensed sales agent or broker for more information. This information is not a complete description of benefits. Contact the plan for more information.

All of the plans in this guide are available in some or all of the counties below. Some plans may be available in other counties as well. BE SURE TO CHECK THE SUMMARY OF BENEFITS, SECTION 1, FOR THE EXACT SERVICE AREA OF EACH PLAN.

AZ: Pima

This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage, please contact your agent or the health plan. Other Pharmacies/Physicians/Providers are available in our network. Out-of-network/non-contracted providers are under no obligation to treat Amerigroup 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. The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2019 Tivity Health, Inc. All rights reserved. LiveHealth® Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Amerigroup.

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability in our health programs and activities. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-248-3295 (TTY: 711). Díj baa akó nínízin: Díj saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jjiik'eh, éi ná hóló, koji' hódílnih 1-855-248-3295 (TTY: 711). Amerigroup Texas, Inc. is a Medicare Advantage Organization with a Medicare contract. Enrollment in Amerigroup Texas, Inc. depends on contract renewal.

- 1 In addition to your monthly Medicare Part B premium.
- 2 The Annual Medical Deductible applies to some in-network Medicare-covered services and all out-of-network Medicare-covered services. Please reference your Evidence of Coverage for details.
- 3 Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
- 4 \$0 copayment applies to Medicare-covered specialist services received through designated care programs.
- 5 Additional coverage may be available at an extra cost. Please reference your Evidence of Coverage for details.



Nurse Helpline



Preventive Services



LiveHealth® Online



SilverSneakers®



Routine Vision



Hearing

Included in all plans: \$0 copay for in-network Medicare-covered Preventive Services including: Annual Wellness Exam, Immunizations, Mammograms, Prostate Cancer Screening Exams, and More. See Evidence of Coverage for details.

Want more? Ask your representative about adding Optional Supplemental Benefits (OSB) to your Medicare Advantage Plan.



Tony Nguyen

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1-520-369-0659

TTY: 711

8 a.m. to 8 p.m.,
7 days a week

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Tôi nói tiếng Việt.

Plan Name	Amerivantage COPD (HMO C-SNP)	Amerivantage Diabetes (HMO C-SNP)	Amerivantage Heart Care (HMO C-SNP)
Monthly Premium ¹	\$0	\$0	\$0
In-Network Out-of-Pocket Limit ²	\$2,700	\$2,700	\$2,700
Monthly Part B Premium Reduction	\$8	\$8	\$8
Inpatient Care³	In-Network	In-Network	In-Network
Inpatient Hospital	Days 1 – 5: \$200 per day, per benefit period/ Days 6 – 90: \$0 per day, per benefit period	Days 1 – 5: \$200 per day, per benefit period/ Days 6 – 90: \$0 per day, per benefit period	Days 1 – 5: \$200 per day, per benefit period/ Days 6 – 90: \$0 per day, per benefit period
Outpatient Care			
Primary Care Doctor Visit	\$0 copay	\$0 copay	\$0 copay
Specialist Visit⁴	\$0 – \$25 copay	\$0 – \$35 copay	\$0 – \$35 copay
Outpatient Hospital Surgery	\$0 copay	\$175 copay	\$175 copay
Urgent Care	\$15 copay	\$15 copay	\$15 copay
Lab Work	\$0 copay	\$0 copay	\$0 copay
Ambulance (Ground)	\$195 copay	\$195 copay	\$195 copay
X-Rays	\$15 copay	\$15 copay	\$15 copay
Dental⁵	This plan covers 2 oral exams every year, 2 cleanings every year, and 1 dental X-ray every year. \$100 benefit allowance every three months.	This plan covers 2 oral exams every year, 2 cleanings every year, and 1 dental X-ray every year. \$100 benefit allowance every three months.	This plan covers 2 oral exams every year, 2 cleanings every year, and 1 dental X-ray every year. \$100 benefit allowance every three months.
Hearing Aid	1 routine hearing test every year and 1 fitting/evaluation for a hearing aid every year. \$0 copay, 2 digital hearing aids or \$1,000 allowance once every 3 years.	1 routine hearing test every year and 1 fitting/evaluation for a hearing aid every year. \$0 copay, 2 digital hearing aids or \$1,000 allowance once every 3 years.	1 routine hearing test every year and 1 fitting/evaluation for a hearing aid every year. \$0 copay, 2 digital hearing aids or \$1,000 allowance once every 3 years.
Routine Vision⁵	1 routine eye exam every calendar year. \$100 eyeglass frame allowance every other calendar year. \$100 contact lens allowance every other calendar year.	1 routine eye exam every calendar year. \$100 eyeglass frame allowance every other calendar year. \$100 contact lens allowance every other calendar year.	1 routine eye exam every calendar year. \$100 eyeglass frame allowance every other calendar year. \$100 contact lens allowance every other calendar year.
Transportation	\$0 copay, 22 one-way trips to plan-approved locations and unlimited trips to designated care programs per year	\$0 copay, 12 one-way trips to plan-approved locations and unlimited trips to designated care programs per year	\$0 copay, 12 one-way trips to plan-approved locations and unlimited trips to designated care programs per year
Diabetic Supplies	\$0 copay	\$0 copay	\$0 copay
Over-the-Counter Allowance	\$100 every quarter	\$75 every quarter	\$75 every quarter
SilverSneakers®	Yes	Yes	Yes
Part D Prescription Drugs — Amounts are for a one-month supply at a preferred cost-sharing pharmacy/standard cost-sharing pharmacy.			
Tier 1: Preferred Generic	\$0 copay/\$5 copay	\$0 copay/\$5 copay	\$0 copay/\$5 copay
Tier 2: Generic	\$7.50 copay/\$12.50 copay	\$7.50 copay/\$12.50 copay	\$7.50 copay/\$12.50 copay
Tier 3: Preferred Brand	\$40 copay/\$45 copay	\$40 copay/\$45 copay	\$40 copay/\$45 copay
Tier 4: Non-Preferred Drugs	\$85 copay/\$95 copay	\$85 copay/\$95 copay	\$85 copay/\$95 copay
Tier 5: Specialty	33% coinsurance/33% coinsurance	33% coinsurance/33% coinsurance	33% coinsurance/33% coinsurance
Tier 6: Select Care Drugs	\$0 copay/\$0 copay	\$0 copay/\$0 copay	\$0 copay/\$0 copay
Part D Gap Coverage Tiers	1, 2, Partial 6	1, 2, Partial 6	1, 2, Partial 6