January 1 – December 31, 2022

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Aetna Medicare Assure (HMO D-SNP)

This booklet gives you the details about your Medicare and Medicaid health care and prescription drug coverage from January 1 – December 31, 2022. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Aetna Medicare Assure (HMO D-SNP), is offered by AETNA HEALTH INC. (FL) (When this *Evidence of Coverage* says "we," "us," or "our," it means AETNA HEALTH INC. (FL) When it says "plan" or "our plan," it means Aetna Medicare Assure (HMO D-SNP).)

This document is available for free in Spanish.
ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-409-1221 (TTY: 711).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-409-1221 (TTY: 711).
Please contact our Member Services number at 1-866-409-1221 for additional information. (TTY users should call 711). Hours of operation are 8 AM to 8 PM, 7 days a week.

This document may be made available in other formats such as braille, large print or other alternate formats.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2023.

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

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OMB Approval 0938-1051 (Expires: February 29, 2024)

Aetna Medicare's pharmacy network includes limited lower cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, and Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Member Services at 1-866-409-1221 (TTY: 711) or consult the online *Provider & Pharmacy Directory* at AetnaMedicare.com/findpharmacy.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call 1-866-409-1221 (TTY: 711) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

2022 Evidence of Coverage

Table of Contents

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Chapter 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1	You are enrolled in Aetna Medicare Assure (HMO D-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Aetna Medicare Assure (HMO D-SNP).

There are different types of Medicare health plans. Aetna Medicare Assure (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. Aetna Medicare Assure (HMO D-SNP) is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Medicaid may also provide other benefits to you by covering health care services or prescription drugs that are not usually covered under Medicare. You may also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. Aetna Medicare Assure (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Aetna Medicare Assure (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the FL Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare and Medicaid medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of Aetna Medicare Assure (HMO D-SNP).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Aetna Medicare Assure (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary),* and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Aetna Medicare Assure (HMO D-SNP) between January 1, 2022 and December 31, 2022.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Aetna Medicare Assure (HMO D-SNP) after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Aetna Medicare Assure (HMO D-SNP) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (Section 2.4 below describes our service area)
- -- *and* -- You are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources). To be eligible for our plan you must be eligible for both Medicare and Medicaid.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost-sharing during a period of deemed continued eligibility).

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home

infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Qualified Medicare Beneficiary Plus (QMB Plus):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). You are also eligible for full Medicaid benefits from your state Medicaid program.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Specified Low-Income Medicare Beneficiary Plus (SLMB Plus):** Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.
- **Full Benefit Dual Eligible (FBDE):** Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.
- **Qualifying Individual (QI):** Helps pay Part B premiums.

Section 2.4 Here is the plan service area for Aetna Medicare Assure (HMO D-SNP)

Although Medicare is a Federal program, Aetna Medicare Assure (HMO D-SNP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in: FL-Charlotte, FL-Collier, FL-Lee.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in **Addendum A** at the back of this booklet.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

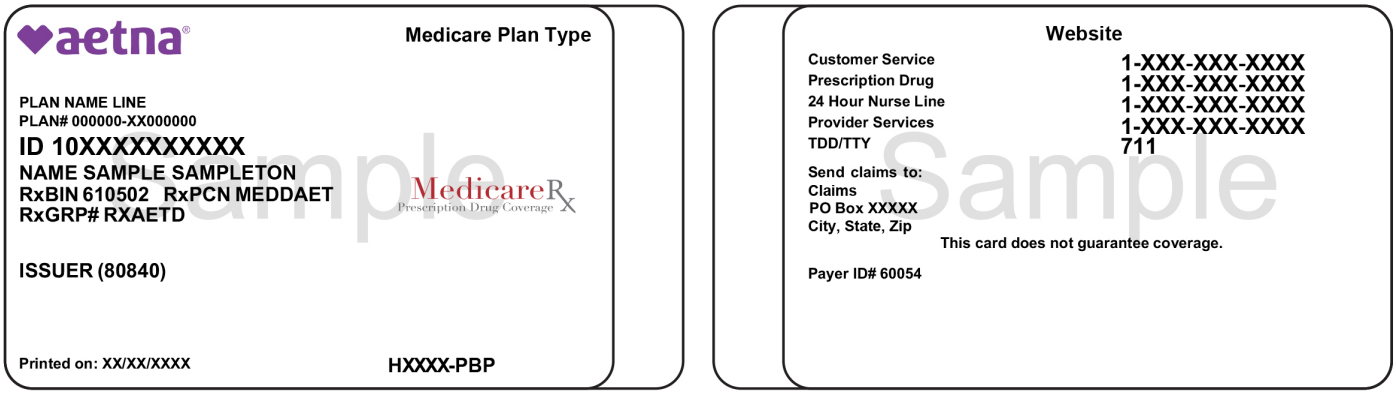
Section 2.5 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Aetna Medicare Assure (HMO D-SNP) if you are not eligible to remain a member on this basis. Aetna Medicare Assure (HMO D-SNP) must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. **You should also show the provider your Medicaid card**. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Aetna Medicare Assure (HMO D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Aetna Medicare Assure (HMO D-SNP) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2	The *Provider & Pharmacy Directory*: Your guide to all providers in the plan's network

The *Provider & Pharmacy Directory* lists our network providers, durable medical equipment suppliers, and identifies participating Medicaid providers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at AetnaMedicare.com/findprovider.

Why do you need to know which providers are part of our network?
It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Aetna Medicare Assure (HMO D-SNP) authorizes use of out-of-network providers. We provide Medicaid health benefits under our plan's network of providers to members that are eligible for full Medicaid benefits. See Chapter 3 *(Using the plan's coverage for your medical services)* for more specific information about emergency, out-of-network, and out-of-area coverage.

It is important to know which participating providers accept Medicare and Medicaid. When you are accessing a Medicaid-covered benefit, be sure to select one that also provides Medicaid-covered services. Providers of Medicaid services are identified with an asterisk in the *Provider & Pharmacy Directory.*

If you don't have your copy of the *Provider & Pharmacy Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications.

Section 3.3 The *Provider & Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?
Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?
You can use the *Provider & Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider & Pharmacy Directory* is located on our website at AetnaMedicare.com/findpharmacy. You may also call Member Services for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2022 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

If you don't have the *Provider & Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at AetnaMedicare.com/findpharmacy.

Section 3.4 The plan's *List of Covered Drugs* (*Formulary*)

The plan has a *List of Covered Drugs* (*Formulary*). We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Aetna Medicare Assure (HMO D-SNP). In addition to the drugs covered by Part D, some prescription drugs are covered for you under your Medicaid benefits.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Aetna Medicare Assure (HMO D-SNP) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (AetnaMedicare.com/formulary) or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.5 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

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

The *Part D Explanation of Benefits* tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefit is used. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options.

The *Part D Explanation of Benefits* is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for Aetna Medicare Assure (HMO D-SNP)

Section 4.1 How much is your plan premium?

As a member of Aetna Medicare Assure (HMO D-SNP), you pay a monthly plan premium unless you qualify for "Extra Help" with your prescription drug costs. You may not pay a monthly plan premium (prescription drug plan premium) if you qualify for "Extra Help". People with Medicare and Medicaid automatically qualify for "Extra Help". For 2022, the monthly premium for our plan is **$0** or up to **$27.30**. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. This situation is described below.

- Some members are required to pay a **Part D late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
    - If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.
    - If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.
    - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage.
- Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium.

Some members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some members are required to pay other Medicare

premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most Aetna Medicare Assure (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be. If you had a life-changing event that caused your income to go down, you can ask Social Security to reconsider their decision.
- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan.**
- You can also visit www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of the *Medicare & You 2022* handbook gives information about these premiums in the section called "2022 Medicare Costs." Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You 2022* handbook from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium. If you did not select a payment option on your enrollment application at the time you enrolled in our plan, we will automatically **set you up on the invoice method** so you can make your plan premium payments by check. If you decide at any time to change your payment method, please call Member Services (phone numbers are printed on the back cover of this booklet).

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check
You may decide to pay your monthly premium to us by check using our invoice method. Please make your checks payable to our plan (which is on your invoice) not to CMS nor HHS. Monthly plan premium payments are due the 1st day of each month for coverage of the current month. We must receive your check and corresponding month's invoice in our office by the 10th of each month to prevent your account from becoming delinquent. All monthly plan premium payments should be sent to the address listed on your payment invoice.

You will receive your first invoice within 45 days of your coverage effective date. You will then receive it every month going forward if a balance is owed. Be sure to include your invoice slip with your check to ensure the appropriate credit is applied to your account. In the event that you need a replacement invoice or you wish to change your payment method, please call Member Services for assistance (phone numbers are on the back cover of this booklet).

Option 2: You can pay at a CVS Pharmacy
You may pay your monthly plan premium at any retail CVS location (excluding CVS Pharmacies in Target and Schnucks) if a barcode is printed on your invoice. You can do this by taking your invoice and having it rung up at the register like any prescription or item you are purchasing. The CVS Associate will ask you how much you would like to pay towards your premium and you will need to confirm the amount on the credit card machine. You will then be able to pay the premium along with any other items you are purchasing with cash or credit cards.

You do not need to fill a prescription or use CVS Pharmacies for any of your prescriptions in order to take advantage of this payment method. You do not need to sign up for any CVS loyalty programs to use this payment method. A unique barcode is assigned to each member so you may not use another person's invoice to pay your bill. This payment method is only available to members with a barcode printed on their monthly invoice. If you have any questions about this payment method, please contact Member Services and not CVS associates. (Phone numbers for Member Services are on the back cover of this booklet.)

Option 3: You can pay by automatic withdrawal
You may decide to pay your monthly premium by an automatic payment from your checking/savings account or credit card by the Electronic Fund Transfer (EFT) option. Your premium will be automatically deducted from your account between the 10th and the 15th of each month unless it is a weekend or bank holiday, then the deduction will occur the next business day. If you are interested in enrolling in this program, please contact Member Services (phone numbers are printed on the back cover of this booklet) or by completing and returning the authorization form located on

your premium invoice.

Option 4: You can have the plan premium taken out of your monthly Social Security check.
You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium
If you are having trouble paying your plan premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Services are printed on the back cover of this booklet).

Section 4.3	Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

Section 5.1	How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider/Medical Group/IPA. A Medical Group is a group of physicians and other health care providers under contract to provide services to members of our plan. An IPA, or Independent Practice Association, is an independent group of physicians and other health care providers under contract to provide services to members of our plan.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have
Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan

member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 **Aetna Medicare Assure (HMO D-SNP) contacts** (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Aetna Medicare Assure (HMO D-SNP) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX	1-866-759-4415
WRITE	Aetna Medicare PO Box 7405 London, KY 40742
WEBSITE	AetnaMedicare.com

How to contact us when you are asking for a coverage decision about your medical care
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions For Medical Care – Contact Information
CALL	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX	1-866-759-4415
WRITE	Aetna Medicare Precertification Unit PO Box 7405 London, KY 40742
WEBSITE	AetnaMedicare.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals For Medical Care – Contact Information
CALL	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX	1-724-741-4953 Expedited appeals: 1-724-741-4958
WRITE	Aetna Medicare Part C Appeals PO Box 14067 Lexington, KY 40512

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints About Medical Care – Contact Information
CALL	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX	1-724-741-4956
WRITE	Aetna Medicare Grievances PO Box 14834 Lexington, KY 40512
MEDICARE WEBSITE	You can submit a complaint about Aetna Medicare Assure (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-800-414-2386 Calls to this number are free. Hours of operation are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 24 hours a day, 7 days a week.
FAX	1-800-408-2386
WRITE	Aetna Medicare Coverage Determinations PO Box 7773 London, KY 40742
WEBSITE	AetnaMedicare.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-833-620-8808 Calls to this number are free. Hours of operation are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 24 hours a day, 7 days a week.
FAX	1-724-741-4954
WRITE	Aetna Medicare Part D Appeals PO Box 14579 Lexington, KY 40512
WEBSITE	AetnaMedicare.com

How to contact us when you are making a complaint about your Part D prescription drugs
You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX	1-724-741-4956
WRITE	Aetna Medicare Grievances PO Box 14834 Lexington, KY 40512
MEDICARE WEBSITE	You can submit a complaint about Aetna Medicare Assure (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services* or drugs*)*.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests for Medical Coverage – Contact Information
FAX	1-866-474-4040
WRITE	Aetna Medicare PO Box 981106 El Paso, TX 79998-1106
WEBSITE	AetnaMedicare.com

Method	Payment Requests for Part D Prescription Drugs – Contact Information
WRITE	Aetna Medicare PO Box 52446 Phoenix, AZ 85072-2446
WEBSITE	AetnaMedicare.com

SECTION 2 **Medicare** (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in

Method	Medicare – Contact Information
	different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Aetna Medicare Assure (HMO D-SNP): • **Tell Medicare about your complaint:** You can submit a complaint about Aetna Medicare Assure (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 **State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Refer to **Addendum A** at the back of this booklet for the name and contact information of the State Health Insurance Assistance Program in your state.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching

plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES

- Visit www.medicare.gov
- Click on "**Forms, Help, and Resources**" on far right of menu on top
- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
  - Option #1: You can have a **live chat**
  - Option #2: You can click on any of the **"TOPICS"** in the menu on the bottom
  - Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 **Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Refer to **Addendum A** at the back of this booklet for the name and contact information of the Quality Improvement Organization in your state.

The QIO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social

Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 **Medicaid** (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

The following "Medicare Savings Programs" help people with limited income and resources:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and

other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Qualified Medicare Beneficiary Plus (QMB Plus):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). You are also eligible for full Medicaid benefits from your state Medicaid program.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Specified Low-Income Medicare Beneficiary Plus (SLMB Plus):** Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.
- **Full Benefit Dual Eligible (FBDE):** Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.
- **Qualifying Individual (QI):** Helps pay Part B premiums.

If you have questions about the assistance you get from Medicaid, contact your state Medicaid agency.

The Ombudsman program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

The LTC Ombudsman program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Refer to **Addendum A** at the back of this booklet for the name and contact information for the Medicaid agency and Ombudsman programs in your state.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Most of our members qualify for and are already getting "Extra Help" from Medicare to pay for their prescription drug plan costs.

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income

and resources. Resources include your savings and stocks, but not your home or car. Those who qualify get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

If you have questions about "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (See **Addendum A** at the back of this booklet for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us. You can send your evidence documentation to us using any of the following contact methods:

Method	Best Available Evidence – Contact Information
WRITE	Best Available Evidence PO Box 7782 London, KY 40742
FAX	1-866-669-2451
EMAIL	BAE/LISmailbox@aetna.com

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we

may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance (telephone numbers are in **Addendum A** at the back of this booklet). Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Refer to **Addendum A** at the back of this booklet for the name and contact information of the ADAP in your state.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP contact. (Refer to **Addendum A** at the back of this booklet for the name and contact information of the ADAP in your state).

What if you get "Extra Help" from Medicare to help pay your prescription drug costs?
Can you get the discounts?
Most of our members get "Extra Help" from Medicare to pay for their prescription drug plan costs. If you get "Extra Help," the Medicare Coverage Gap Discount Program does not apply to you. If you get "Extra Help," you already have coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?
If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in **Addendum A** at the back of this booklet) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

Chapter 3

Using the plan's coverage for your medical and other covered services

Chapter 3. Using the plan's coverage for your medical and other covered services

SECTION 1 Things to know about getting your medical care and other services covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for covered services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and Medicaid health plan, Aetna Medicare Assure (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare (See the *Medical Benefits Chart* in Chapter 4, Section 2.1).

Aetna Medicare Assure (HMO D-SNP) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions*:
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care and other services

What is a "PCP" and what does the PCP do for you?

As a member of our plan, you must have a network PCP on file with us. It is very important that you choose a network PCP and tell us who you have chosen. Your PCP can help you stay healthy, treat illnesses and coordinate your care with other health care providers. Your PCP will appear on your ID card. If your ID card does not show a PCP or the PCP on your card is not the one you want to use, please contact us immediately.

Depending on where you live, the following types of providers may act as a PCP:

- General Practitioner
- Internist
- Family Practitioner
- Geriatrician
- Physician Assistants (Not available in all states)
- Nurse Practitioners (Not available in all states)

Please refer to your *Provider & Pharmacy Directory* or go to our website at AetnaMedicare.com/findprovider for a complete listing of PCPs in your area.

What is the role of a PCP in coordinating covered services?

Your PCP will provide most of your care, and when you need more specialized services, they will coordinate with other providers. They will help you find a specialist and will arrange for covered services you get as a member of our plan. Some of the services that the PCP will coordinate include:

- x-rays;
- laboratory tests;
- therapies;
- care from doctors who are specialists; and
- hospital admissions.

"Coordinating" your services includes consulting with other plan providers about your care and how it is progressing. Since your PCP will provide and coordinate most of your medical care, we recommend that you have your past medical records sent to your PCP's office. Certain types of covered services may require a referral from your PCP.

What is the role of the PCP in making decisions about or obtaining prior authorization?

In some cases, your PCP or other provider or you as the enrollee (member) of the plan may need to get approval in advance from our Medical Management Department for certain types of services or tests (this is called getting "prior authorization"). Obtaining prior authorization is the responsibility of the PCP, treating provider or you as the member. Services and items requiring prior authorization

are listed in Chapter 4.

How do you choose your PCP?
You can select your PCP by using the *Provider & Pharmacy Directory,* by accessing our website at AetnaMedicare.com/findprovider, or getting help from Member Services (phone numbers are printed on the back cover of this booklet).

If you have not selected a PCP, a PCP will be selected for you. You can change your PCP (as explained later in this section) for any reason, any time by contacting Member Services (phone numbers are printed on the back cover of this booklet) with your PCP choice.

If there is a particular plan specialist or hospital that you want to use, check first to be sure that your PCP makes referrals to that specialist, or uses that hospital.
The name and/or office telephone number of your PCP is printed on your membership card. If you use a PCP that is not printed on your ID card, you may incur a higher cost share or your claims may be denied.

Changing your PCP
You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. If you use a PCP that is not printed on your ID card, you may incur a higher cost share or your claims may be denied. Contact us immediately if your ID card does not show the PCP you want to use. We will update your file and send you a new ID card to reflect the change in PCP.

To change your PCP, call Member Services (phone numbers are printed on the back of this booklet) **before** you set up an appointment with a new PCP. When you call, be sure to tell Member Services if you are seeing specialists or currently getting other covered services that were coordinated by your PCP (such as home health services and durable medical equipment). They will check to see if the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, let you know the effective date of your change request, and answer your questions about the change. They will also send you a new membership card that shows the name and/or phone number of your new PCP.

Section 2.2 What kinds of medical care and other services can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 2.3 How to get care from specialists and other network providers

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

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

What is the role of the PCP in referring members to specialists and other providers?
Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member.
If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). If you use a PCP that is not printed on your ID card or see a specialist without a referral, you may incur a higher cost share or your claims may be denied. For more details about which services require a referral from your PCP, please contact us. Phone numbers for Member Services are printed on the back cover of this booklet.

Prior Authorization Process
In some cases, your PCP or other provider or you as the enrollee (member) of the plan may need to get approval in advance from our Medical Management Department for certain types of services or tests that you receive in-network (this is called getting "prior authorization"). Obtaining prior

authorization is the responsibility of the PCP or treating provider or you as the member. Services and items requiring prior authorization are listed in *Medical Benefits Chart* in Chapter 4, Section 2.1.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider to manage your care.

You may contact Member Services (phone numbers are printed on the back cover of this booklet) for assistance. You may also look up participating providers using the *Provider & Pharmacy Directory* or online at our website at AetnaMedicare.com/findprovider.

Section 2.4 How to get care from out-of-network providers

As a member of our plan, you must use network providers. If you receive unauthorized care from an out-of-network provider, we may deny coverage and you will be responsible for the entire cost. *Here are three exceptions*:

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior

Authorization should be obtained from the plan prior to seeking care. In this situation, if the care is approved, you would pay the same as you would pay if you got the care from a network provider. Your PCP or other network provider will contact us to obtain authorization for you to see an out-of-network provider.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

You should ask the out-of-network provider to bill us first. If you have already paid for the covered services or if the out-of-network provider sends you a bill that you think we should pay, please contact Member Services (phone numbers are printed on the back of this booklet) or send us the bill. See Chapter 7 for information on how to ask us to pay you back or to pay a bill you have received.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "**medical emergency**" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services (phone numbers are printed on the back cover of this booklet).

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits

Chart in Chapter 4 of this booklet.

Our plan also covers worldwide services outside of the United States under the following circumstances:

- Emergency care
- Urgently needed care
- Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the Medical Benefits Chart in Chapter 4 for more information.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?
Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* –The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2	Getting care when you have an urgent need for services

What are "urgently needed services"?
"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?
You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

If you need to locate an urgent care facility, you can find an in-network urgent care center near you by using the *Provider & Pharmacy Directory*, going to our website at AetnaMedicare.com/findprovider, or getting help from Member Services (phone numbers are printed on the back cover of this booklet).

What if you are outside the plan's service area when you have an urgent need for care?
When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan also covers worldwide services outside of the United States under the following circumstances:

- Emergency care
- Urgently needed care
- Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the Medical Benefits Chart in Chapter 4 for more information.

Section 3.3 Getting care during a disaster

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

Please visit the following website: AetnaMedicare.com for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your covered services?

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Aetna Medicare Assure (HMO D-SNP) covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized. Before paying for the cost of the service, contact Member Services (phone numbers are printed on the back cover of this booklet) to find out if the service is covered.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone

numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay for services after a benefit limit has been reached do not count toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost-sharing works*: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving care From a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan*'s* coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage has unlimited additional days (see the Benefits Chart in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan we will transfer ownership of certain DME items. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for ownership of oxygen equipment, supplies, and maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Aetna Medicare Assure (HMO D-SNP) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Aetna Medicare Assure (HMO D-SNP) or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is$0 every time that you obtain services.

Your cost-sharing will not change after being enrolled for 36 months in Aetna Medicare Assure (HMO D-SNP).

If prior to enrolling in Aetna Medicare Assure (HMO D-SNP) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Aetna Medicare Assure (HMO D-SNP) is $0.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five

years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining Aetna Medicare Assure (HMO D-SNP), join Aetna Medicare Assure (HMO D-SNP) for 12 months, and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in Aetna Medicare Assure (HMO D-SNP) and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

Chapter 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on what services are covered and what you pay for these services. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Aetna Medicare Assure (HMO D-SNP). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Section 1.2 What is the most you will pay for covered medical services?

Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Aetna Medicare Assure (HMO D-SNP), the most you will have to pay out-of-pocket for services in 2022 is $3,450. The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket

amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of $3,450, you will not have to pay any out-of-pocket costs for the rest of the year for covered services.

However, you must continue to pay for your plan premiums and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to “balance bill” you

As a member of Aetna Medicare Assure (HMO D-SNP), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has “balance billed” you, call Member Services (phone numbers are printed on the back cover of this booklet).

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

for a service. If you receive a bill from a provider, call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Aetna Medicare Assure (HMO D-SNP) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart.
- We may also charge you "administrative fees" for missed appointments or for not paying your required cost-sharing at the time of service. Call Member Services if you have questions regarding these administrative fees. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services, including

payments of Medicare Parts A & B premiums, deductibles, coinsurance and copayments (except for Medicare Part D) depending on your Medical Savings Program eligibility. Medicaid may also cover services that Medicare does not cover, like additional home health services.

- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2022* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.
- Under our plan, if you are eligible for full Medicaid, we will provide coverage for some Medicaid benefits as required in our plan's agreement with your State Medicaid Agency. The benefits chart in Chapter 4 states what benefits are covered under the plan. The benefits chart will also state any benefit limitations or authorizations that apply.
- If you are within our plan's 6-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan covered Medicare benefits. We will also continue to cover the Medicaid benefits that are covered by your plan. You will fall into the deeming period if you lose your Medicaid eligibility or your Medicare Savings Program eligibility. The deeming period begins the first day of the month after you lose your dual eligible status. When you are in the period of deemed continued eligibility, you are still a member of Aetna Medicare Assure (HMO D-SNP). However, during this period, you might be responsible for some out-of-pocket costs that were previously paid for by your Medicaid benefits.

  Costs you might have to pay for include Part A or B premiums, depending on your level of Medicaid eligibility. You might also have to pay for Part D premiums or Part D drug cost-shares based on your level of "Extra Help." Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period. If you don't re-qualify for Medicaid benefits or enroll in a different Medicare plan at the end of the six-month deeming period, we will disenroll you from Aetna Medicare Assure (HMO D-SNP).

If you are eligible for Medicare cost-sharing assistance under Medicaid, you do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

- This means, if you are eligible for Medicare cost share protection (Cost Share Protected Members), you will not pay any Medicare Part A and B deductibles, coinsurance and copayments.

  OR

- If you are NOT eligible for Medicare cost share protection (Non-Cost Share Protected Members), you may have to pay Medicare Part A and B deductibles, coinsurance and copayments.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

Medicare approved Aetna Medicare to provide these benefits and/or lower co-payments/co-insurance as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

- Because Aetna Medicare Assure (HMO D-SNP) participates in the Part D reduction program that offers benefits to help support your healthcare needs, you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - If you are unable to make decisions for yourself in the future about your healthcare, medical professionals can make sure your wishes are followed. Advance care planning means having conversations and making decisions about the care you would like in the future.
  - We will assist you with the necessary forms that you need to give someone the legal authority to make medical decisions for you if you ever become unable to make them for yourself.
- You may get advance care planning assistance by contacting the Care Team at 800-241-9379.
- WHP and ACP are voluntary and you are free to decline these services.

Important Benefit Information for Enrollees Who Qualify for “Extra Help”:

- If you receive "Extra Help" to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- Please go to the Medical Benefits Chart in Chapter 4 for further detail.
- Members qualify for the elimination of their cost sharing for Part D drugs. See Chapter 5 for

further detail.

For a list of Medicaid benefits, please refer to the Summary of Medicaid-Covered Benefits in the *Summary of Benefits*. You can find a copy of your plan's *Summary of Benefits* on our website at AetnaMedicare.com or call Member Services (phone numbers are printed on the back cover of this booklet) to request a copy. You may also contact the state Medicaid agency listed in **Addendum A** to determine your level of cost-sharing for Medicaid benefits that are covered for you.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	$0 copay for each Medicare-covered acupuncture visit. $0 copay for each additional acupuncture visit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. In addition to Medicare-covered benefits, we also offer:	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Acupuncture services to treat conditions in addition to chronic lower back pain: up to twenty visits every year***** Covered services must be performed by a licensed acupuncturist for the relief of musculoskeletal pain conditions and nausea from pregnancy, immediate post-surgery, and chemotherapy. We have partnered with American Specialty Health (ASH) to provide your acupuncture coverage. On your initial visit, your provider will discuss and establish your treatment plan and review any medical necessity requirements to continue treatment after the initial treatment plan has concluded. Establishing medical necessity is the responsibility of ASH and your provider. To locate a network provider, you may contact Member Services at the number on the back of your ID card or search our online directory. If you choose to use a provider outside of our network, the services you receive will not be covered. Covered services do not include acupuncture for: • Weight loss • Sexual dysfunction • Mental conditions such as depression, smoking cessation, or drug or alcohol addiction • Any other conditions that do not meet coverage	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
criteria	
Allergy services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include services that provide diagnostic and therapeutic procedures relating to hypersensitivity disorders that may be manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body. Covered medically necessary services include: Allergy testing as follows: • In vitro specific IgE tests • Intracutaneous skin tests • Percutaneous skin tests • Ingestion challenge testing Allergen immunotherapy as follows: • Up to 156 doses every 366 days • Up to 52 doses every 366 days **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. **Prior authorization is required for non-emergency transportation by fixed-wing aircraft.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 - $200 copay for each Medicare-covered one-way trip via ground ambulance. $0 - 20% coinsurance for each Medicare-covered one-way trip via air ambulance. Ground or air ambulance cost-sharing is not waived if you are admitted to the hospital.
Anesthesia services (Medicaid) Additional services may be available under the Medicaid portion of the plan's benefits. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" preventive visit. You may schedule your annual routine physical once each calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. Please see "**Outpatient diagnostic tests and therapeutic services and supplies**" for more information.	$0 copay for an annual routine physical.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Assistive care services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include services that enables recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. Florida Medicaid covers 365/366 days of continuous assistive care services per year, per member, in order to provide assistance with ADLs, IADLs, and self-administration of medication when the recipient meets the following criteria: • Has a medical condition or disability that substantially limits his or her ability to perform ADLs or IADLs • Has a health assessment that documents the need for assistive care services **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Behavioral health assessment services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Behavioral health assessment services provide screenings and identification of mental health and substance use disorders to develop, plan, and maintain a schedule of services to restore a member to the best possible functional level. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Behavioral health community support services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Behavioral health community support services promote recovery from behavioral health disorders or cognitive symptoms by improving the ability of members to strengthen or regain skills necessary to function successfully. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Behavioral health intervention services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Behavioral health intervention services which enable members to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social, and prevocational life management services. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Behavioral health medication management services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Behavioral health medication management (BHMM) including medication assisted treatment in conjunction with psychiatric evaluations, counseling, and behavioral therapies for a comprehensive treatment approach to behavioral health and substance use disorder. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Behavioral health overlay services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary on-site clinical and support services: • Individual, family, and group therapy • Individualized behavior management services (including design, consultation, and supervision), when indicated • Therapeutic support services • Discharge and aftercare planning (including identification of behavioral health services needed for successful discharge from behavioral health overlay services and transition into the appropriate level of care) **Members must meet specific criteria and prior authorization applies.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Behavioral health therapy services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Behavioral health therapy provides services to the recipients, their families, or other responsible persons to improve the symptoms of the recipient's mental health or substance use disorder(s) using evidence-based, insight-oriented, therapeutic interventions. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms. $0 copay for each diagnostic mammogram.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services.
🍎 **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Child health services targeted case management (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Targeted case management services are available to members in gaining access to needed medical, social, educational, and other services. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation In addition to Medicare-covered benefits, we also offer: • Additional chiropractic services: up to twelve visits every year Services include, but are not limited to, evaluation and management, X-ray examination, chiropractic manipulative therapy, modalities and therapeutic procedures, physical rehabilitation for musculoskeletal conditions of the spine and extremities. To locate a network provider, you may contact Member Services at the number on the back of your ID card or search our online directory. If you choose to use a provider outside of the network, the services you receive will not be covered. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered chiropractic visit. $0 copay for each non-Medicare covered additional chiropractic visit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Chiropractic services (Medicaid) Additional services available under the Medicaid portion of the plan's benefits include: Medically necessary chiropractic services: • Up to 24 visits per year, per member • X-rays	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months Two of the following per calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered preventive barium enema. If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology will be covered at $0 copay as these procedures were performed during a preventive service. If you have had polyps removed during a previous colonoscopy or have a condition that is monitored via colonoscopy (such as a prior history

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
	of colon cancer), ongoing colonoscopies are considered diagnostic, are not considered preventive screenings, and are subject to the outpatient surgery cost-sharing. (See "**Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**" for more information.)
Dental services (additional) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Preventive dental services ◦ Oral exams***** ◦ Cleanings***** ◦ Fluoride treatments***** ◦ Dental x-rays***** • Comprehensive dental services ◦ Non-routine services***** ◦ Diagnostic services***** ◦ Restorative services***** ◦ Endodontics services***** ◦ Periodontics services***** ◦ Extractions*****	Non-Medicare covered preventive dental services: • Oral exams: $0 copay (see schedule of benefits) • Cleanings: $0 copay (two visits every year) • Fluoride treatments: $0 copay (one visit every six months) • Dental x-rays: $0 copay (see schedule of benefits) Non-Medicare covered comprehensive dental services: • Non-routine services: $0 copay (see schedule of benefits) • Diagnostic services: $0 copay (see schedule of benefits) • Restorative services: $0 copay (see

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
○ Prosthodontics and maxillofacial services***** Our plan has partnered with Liberty Dental to provide your dental benefits. To locate a network provider, you may contact Member Services at (866) 610-0282 or search the Liberty Dental online provider directory at libertydentalplan.com/AetnaMedicare. If you choose to use a provider outside of the network, the services you receive will not be covered.	schedule of benefits) • Endodontics: $0 copay (see schedule of benefits) • Periodontal services: $0 copay (see schedule of benefits) • Extractions: $0 copay (see schedule of benefits) • Prosthodontics and maxillofacial services: $0 copay (see schedule of benefits) (See "**Physician/ Practitioner services, including doctor's office visits**" for information about Medicare-covered dental services.)
Dental services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary dental services as follows: Adjunctive General Services: • Behavioral management when provided in connection with a covered dental service • Intravenous/Non-Intravenous Sedation up to three times Diagnostic Services: • Oral Evaluations	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	

• Comprehensive evaluation every three years
• Limited evaluations, as medically indicated
 	
Diagnostic Imaging:
 	
• One complete series of intraoral radiographs every three years
• One panoramic radiograph every three years
 	
Prosthodontics Services:
Prosthodontics services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:
 	
• One of the following:
  ◦ One upper set
  ◦ One lower set
  ◦ One complete set of full dentures
  ◦ Removable partial dentures
• One reline, per denture, per 366 days
 	
Additional general, diagnostic, endodontic, orthodontic, periodontal, and preventive services may be available to members under the age of 21.
 	
Prior authorization may be required.	

Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	0% coinsurance for each Medicare-covered supply to monitor blood glucose. $0 copay for Medicare-covered diabetic shoes and inserts. $0 copay for Medicare-covered diabetes self-management training.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Diabetes self-management training is covered under certain conditions. **We cover diabetic supplies made by OneTouch/LifeScan. We exclusively cover OneTouch/LifeScan glucose monitors and test strips. We also cover OneTouch/LifeScan lancets, solutions and lancing devices. We do not cover other brands of monitors and test strips unless you or your provider requests a medical exception and it is approved. If the medical exception is approved, a 0% coinsurance will apply. Non-LifeScan monitors and test strips without a medical exception, or a medical exception that is not approved, will not be covered.** **Note: Continuous Glucose Monitors (CGMs) are considered Durable Medical Equipment (DME) and are subject to applicable DME cost-sharing.** **Prior authorization is required for more than one blood glucose monitor per year and/or test strips in excess of 100 strips per 30 days.** **Prior authorization may be required for diabetic shoes and inserts.** **Prior authorization is the responsibility of your provider.**	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Dialysis Services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services for Hemodialysis and Peritoneal dialysis treatments. Medicaid covered services include: • All supervision and management of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions), and all necessary training and monitoring for recipients receiving peritoneal dialysis treatment. • 500 units (500,000 injectable units) of Erythropoietin (EPO, Epogen) per month. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.	$0 copay for each Medicare-covered durable medical equipment item. $0 copay for covered home infusion drugs that are processed under your medical benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at: AetnaMedicare.com/findprovider. Home infusion drugs: Home infusion drugs that are processed under your medical benefits* **Prior authorization may be required and is the responsibility of your provider.** Additional services may be available under the Medicaid portion of the plan's benefits, including, but not limited to, specialized medical equipment and supplies (e.g., incontinence supplies) to enrollees with a diagnosis of AIDS. **Prior authorization may be required.**	
Early intervention services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Early intervention services (EIS) provide early identification and treatment of recipients under the age of three years (36 months) with developmental delays or related conditions. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. In addition to Medicare-covered benefits, we also offer: • Emergency care (worldwide) • Emergency ambulance services (worldwide)	$0 - $90 copay for emergency care. Cost-sharing is waived if you are admitted to the hospital within 24 hours. $0 copay for emergency care worldwide (i.e. outside the United States). $0 copay for emergency ambulance services worldwide (i.e. outside the United States). If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Fall prevention Our plan provides you with a $150 annual allowance for purchasing certain clinically appropriate home and bathroom safety devices that can help you manage physical impairments and improve your ability to move safely around your home. Please call the number on the back of your ID card if you have questions about these safety items or to learn more about this benefit. Covered items will be shipped directly to you. You will be responsible for installation and assembly. There is a limit of 3 orders per year, even if you have not exceeded the annual allowance.	There is no coinsurance, copayment, or deductible for certain clinically appropriate home and bathroom safety devices.
Fitness program You are covered for a basic membership to a SilverSneakers® participating fitness facility. At-home fitness kits and online classes are also available for members who do not reside near a participating club or prefer to exercise at home. Members may order one fitness kit per year through SilverSneakers. Call SilverSneakers at 1-888-423-4632 for assistance. (For TTY/TDD assistance, please dial 711.) Visit Silversneakers.com to find a participating location near you.	$0 copay for health club membership/fitness classes.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Gastrointestinal services (Medicaid) Additional coverage under the Medicaid portion of the plans benefits include medically necessary services that provide diagnostic and therapeutic procedures relating to digestive disorders. Covered medically necessary services include: • Restrictive bariatric surgeries that shrink the size of the stomach reducing the amount of food that it can hold; • Malabsorptive bariatric surgeries that rearrange and/or remove part the digestive system limiting the amount of calories and nutrients that can be absorbed; • Combination bariatric surgeries that combine both restrictive and malabsorptive techniques; • Bariatric surgery revisions, reversals or conversions for complications related to the surgery; • Gastroenterology; • Gastric Physiology **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Genitourinary services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services that provide diagnostic and therapeutic procedures relating to genital and urinary disorders. Covered medically necessary services include: • Endocrine surgical services; • Endocrinology; • Female genital surgical services; • Male genital surgical services • Urinary surgical services **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Health and wellness education programs • **Written health education materials:** Members are eligible to receive the health education supplemental benefit to support a healthier lifestyle. This benefit gives members the opportunity to interact as a group, one-on-one, or virtually, with a certified health educator or other qualified health professional. Members may receive educational supplies such as books and pamphlets to augment their interactive sessions. In addition, members will be encouraged to adopt healthy habits and build skills to enhance self-care capabilities. • **24-Hour Nurse Line:** Talk to a registered nurse 24 hours a day, 7 days a week. Please call 1-855-493-7019 (For TTY/TDD assistance, please dial 711).	$0 copay for written health education materials. $0 copay for 24-Hour Nurse Line services.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Healthy foods card The Healthy Foods Card is a benefit card with a $25 monthly allowance towards the purchase of healthy and nutritious foods and produce. Approved items can be purchased at approved locations to assist members in maintaining a healthy diet to support their nutritional needs. The benefit card will be mailed directly to members and replenished at the beginning of each month. Any unused allowance will not be rolled over into the following month. Please call (Healthy Benefits Plus) at 1-833-451-4662 for more information on this benefit.	There is no coinsurance, copayment, or deductible for this supplemental benefit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. In addition to Medicare-covered benefits, we also offer: • Routine hearing exams: one exam every year • Hearing aid fitting/evaluation: one hearing aid fitting/evaluation every year • Hearing aids: two hearing aids every year***** **Non-Medicare covered hearing aid maximum benefit:** Plan pays up to $2,500 per ear for hearing aids every year. You are responsible for any amount above the hearing aid coverage limit. Our plan has partnered with NationsHearing to provide your hearing exam and hearing aid benefit. All appointments must be scheduled through NationsHearing by calling 1-877-225-0137. If you choose to schedule an appointment directly with a provider, your services will not be covered.	$0 copay for each Medicare-covered hearing exam. $0 copay for each non-Medicare covered routine hearing exam. $0 copay for each non-Medicare covered hearing aid fitting/evaluation. Hearing aids: • $0 copay (two hearing aids every year)

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Hearing services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services that provide screening, assessment and testing services, and appropriate hearing devices to members in order to detect and mitigate the impact of hearing loss. Covered medically necessary services include: • Diagnostic Audiological Tests • Cochlear Implants • Hearing aids ◦ One new complete hearing aid device per ear, every three years ◦ Up to three pairs of ear molds per year ◦ One fitting and dispensing service per ear • Repair and replacement of hearing devices ◦ Repairs and replacement of both Medicaid and non-Medicaid provided hearing aids ◦ Up to two hearing aid repairs every 366 days, after the one year warranty period has expired ◦ Bone anchored hearing aid external components and cochlear implant components, including batteries, after the manufacturer's warranty or insurance protection plan coverage period has expired	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered home health service. $0 copay for each Medicare-covered durable medical equipment item.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Home health services (Medicaid) Additional coverage under the Medicaid portion of the plans benefits include medically necessary services that provide home health visits that provide medically necessary skilled nursing and home health aide services to members whose medical condition, illness, or injury requires the care to be delivered in their home or in the community. Covered medically necessary services include: • Up to four intermittent home health visits, per day, for members under the age of 21 years • Up to three intermittent home health visits, per day, for members age 21 years and older	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan. Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You will pay the cost-sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. See "**Physician/Practitioner Services, Including Doctor's Office Visits"** or "**Home Health Agency Care"** for any applicable cost-sharing. Please note that home infusion drugs, pumps, and devices provided during a home infusion therapy visit, are covered separately under your **"Durable Medical Equipment (DME) and related supplies"** benefit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services related to your terminal diagnosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Aetna Medicare Assure (HMO D-SNP). Hospice consultations are included as part of inpatient hospital care. Physician service cost-sharing may apply for outpatient consultations.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Aetna Medicare Assure (HMO D-SNP) but are not covered by Medicare Part A or B: Aetna Medicare Assure (HMO D-SNP) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 *(What if you're in Medicare-certified hospice).* Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. **Note**: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B, and COVID-19 vaccines.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Days covered: There is no limit to the number of days covered by our plan. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-	Cost-sharing is charged for each inpatient stay. You pay $0 per stay for each medically necessary inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities, is considered a new admission. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Aetna Medicare Assure (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. All components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. Days covered: There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	Cost-sharing is charged for each medically necessary covered inpatient stay. You pay $0 per stay for each medically necessary inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities is considered a new admission.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your skilled nursing facility benefits, or if the skilled nursing facility or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests)	$0 copay for Medicare-covered primary care physician (PCP) services (including telehealth services and urgently needed services). $0 copay for physician specialist services (including surgery second opinion, telehealth services, home infusion professional services, and urgently needed services). $0 copay for each Medicare-covered

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	diagnostic procedure and test. $0 copay for each Medicare-covered lab service. $0 copay for each Medicare-covered CT scan. $0 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 copay for each Medicare-covered X-ray. $0 copay for each Medicare-covered therapeutic radiology service. $0 copay for Medicare-covered medical supplies. $0 copay for each Medicare-covered prosthetic device. $0 copay for each Medicare-covered physical and speech therapy service. $0 copay for each Medicare-covered occupational therapy service.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Integumentary services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary integumentary services that provide diagnostic and therapeutic procedures relating to disorders of the skin and associated structures. Medically necessary services may include: • Active wound care management • Dermatological procedures • Integumentary surgical services including: ◦ Breast reconstruction ◦ Gynecomastia surgery ◦ Reduction Mammoplasty **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Meal benefit After discharge from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to your home, you may be eligible to receive up to 42 meals over a 14-day period* delivered to your home. After our plan confirms that this benefit will help support your recovery or manage your health conditions, and is not based solely on convenience or comfort purposes, you will be contacted by our partner, Independent Living Systems, to schedule delivery. **Note:** Observation stays do not qualify you for this benefit.	$0 copay for covered meals.
Medical foster care services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Medical Foster Care Services provide care to recipients with complex medical needs to enable them to live in a foster care home. **Prior authorization may be required**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Medical massage therapy (Medicaid) Medically necessary massage therapy services may be available under the Medicaid portion of the plan's benefits to enrollees diagnosed with AIDS, and who have had a history of an AIDS-related opportunistic infection for the treatment of peripheral neuropathy or severe neuromuscular pain and lymphedema by medical massage. **Prior authorization may be required and the health plan may limit medical massage services based on medical necessity.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. In addition to Medicare-covered benefits, we also offer: • Additional sessions of medical nutrition therapy: unlimited visits every year for Medicare-covered and non-Medicare covered diseases.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. $0 copay for each additional session of medical nutrition therapy.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor	$0 - 20% coinsurance for chemotherapy drugs. $0 - 20% coinsurance for all other drugs covered under Medicare Part B. Part B drugs may be subject to step therapy requirements.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: Aetna.com/PartB-Step We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. **Prior authorization may be required and is the responsibility of your provider.**	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Mental health targeted case management (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary mental health targeted case management services that provide assistance to members in gaining access to needed medical, social, educational, and other services. **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Neurology services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include neurology services that provide diagnosis and Treatment of diseases and disorders of the nervous system. Covered medically necessary services include: • Autonomic function testing • Electrooculogram • Electrodiagnostics, including nerve conduction studies and electromyography • Electroencephalograph for sleep studies and seizure activity • Evoked potentials and reflex tests • Intrathecal baclofen therapy pump placement, removal, or revision • Muscle and range of motion testing • Muscle testing and guidance for chemodevervation • Polysomnography and sleep studies indicated for the following:	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
◦ Diagnosis of sleep related breathing disorders ◦ Continuous Positive Airway Pressure titration in recipient's sleep related breathing disorders ◦ Documenting the presence of obstructive sleep apnea prior to surgical interventions ◦ Assessment of treatment results in some cases, with a multiple sleep latency test in the evaluation of suspected narcolepsy ◦ Evaluating sleep related behaviors that are injurious, and in certain atypical or unusual parasomnias • Up to two nerve conduction velocity (NCV) studies for polyneuropathy in diabetes per year, per recipient • Vagus nerve stimulator (VNS) placement, removal, or revision for intractable epilepsy **Prior authorization is required.**	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Nursing facility (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include nursing facility services not covered by your Medicare benefits as follows: • Covered for members under the age of 18 • For members over the age of 18, nursing facility services are covered in the following circumstances: ◦ For up to one-hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer, when: ◦ The enrollee is in need of long-term nursing facility services; ◦ The enrollee has completed all Preadmission Screening and Resident Review (PASRR) requirements; ◦ DCF has determined the enrollee is eligible for Institutional Care Program (ICP) Medicaid; and ◦ The member is not yet enrolled in the Medicaid Long Term Care Program **Prior authorization may be required and is the responsibility of your provider.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist treatment medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered opioid use disorder treatment service.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Oral and maxillofacial surgery (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary surgery services to treat diseases, defects and injuries. Covered medically necessary services include: • Biopsies • Bone, tissue, and cartilage grafts • Consultations • Debridement • Endosteal implants when used in conjunction with reconstructive surgeries • Evaluation and management • Excisions • Impressions and custom preparation of prosthesis • Moderate sedation • Open and closed treatment of fractures • Repair and destruction of lesions • Reconstructions • Radiology procedures • Surgical procedures essential to the preparation of the mouth for dentures • Tissue repair **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Orthopedic services (Medicaid) Additional medically necessary orthopedic services may be available under the Medicaid portion of the plan's benefits including procedures for the correction or prevention of deformities, disorders, and injuries of the skeleton and associated structures. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered X-ray. $0 copay for each Medicare-covered therapeutic radiology service. $0 copay for Medicare-covered medical supplies. $0 copay for each Medicare-covered lab service. $0 copay for Medicare-covered and non-Medicare covered blood services. $0 copay for each Medicare-covered CT scan. $0 copay for each Medicare-covered diagnostic radiology service other

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
	than CT scans. $0 copay for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered retinal fundus service. An additional cost share may apply if you receive services from multiple providers.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copay for outpatient hospital observation services.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or	$0 - $90 copay for emergency care. Cost-sharing is waived if you are admitted to the hospital within 24

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-	hours. $0 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. $0 copay for outpatient hospital observation services. $0 copay for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered lab service. $0 copay for each Medicare-covered CT scan. $0 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 copay for each Medicare-covered X-ray. $0 copay for each Medicare-covered therapeutic radiology service. $0 copay for each Medicare-covered individual session for outpatient

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	mental health services provided by a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered individual session for outpatient mental health services provided by a mental health professional other than a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a mental health professional other than a psychiatrist. $0 copay for each Medicare-covered partial hospitalization day. $0 copay for Medicare-covered medical supplies. $0 - 20% coinsurance for chemotherapy drugs. $0 - 20% coinsurance for all other

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
	drugs covered under Medicare Part B.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. We also cover some telehealth visits with psychiatric and mental health professionals. See **"Physician/Practitioner services, including doctor's office visits"** for information about telehealth outpatient mental health care. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered individual session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered individual session for outpatient mental health services provided by a mental health professional other than a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a mental health professional other than a psychiatrist.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered occupational therapy service. $0 copay for each Medicare-covered physical and speech therapy service.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Outpatient substance abuse services Our coverage is the same as Original Medicare's which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment. • Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered individual outpatient substance abuse session. $0 copay for each Medicare-covered group outpatient substance abuse session.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center. $0 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility.
Over-the-Counter (OTC) items We pay up to $225 quarterly for the purchase of covered over-the-counter (OTC) items. You can order items in the OTC catalog as long as the total purchase price is equal to or less than $225*****. This plan comes with a quarterly allowance for OTC medications and supplies. For a complete list of covered items, please refer to the OTC catalog.	There is no coinsurance, copayment, or deductible for covered OTC items. This benefit includes certain nicotine replacement therapies.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
You may place up to three orders each quarter and are limited to up to nine (9) like items per quarter (every three months), with the exception of blood pressure monitors and pillbox with alert reminders, which are limited to one per year. Orders cannot exceed your quarterly allowance. Any unused allowance will not be rolled over into the following quarter. **Notes:** • You cannot pay out-of-pocket for the difference above your allowance. • The OTC limits apply to all orders including in-store/retail transactions, where available. • Reimbursements are not allowed for this benefit. Items purchased outside of the benefit are not covered or reimbursable. Members cannot mail in their OTC order to Member Services. • Quantity limits may apply to select items. OTC Vendor: OTC Health Solutions Items may be ordered over the phone at 1- 833-331-1573 (TTY: 711) Monday-Friday 9 am-8 pm local time (except Hawaii) or online at cvs.com/otchs/myorder to be shipped to your home. You can place an order online 24 hours a day, 7 days a week (24/7). Ordered items are for enrollee only. Items can also be obtained at select participating CVS	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
retail locations by presenting your member ID card at check-out. You can use the store locator at cvs.com/otchs/myorder/storelocator to determine if there is a participating store near you.	
Pain management (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services for the treatment of pain using nerve blocks or steroid injections. Covered medically necessary services include: • Up to 12 facet joint injections, with or without steroids, performed under fluoroscopic guidance for the treatment of acute and chronic neck and low back pain in a six month period, per recipient, for the following: ◦ Diagnostic trial to determine the origin of pain ◦ Therapeutic injection when conservative treatment (oral medications, rest and limited activity, or physical therapy) has failed • Up to four percutaneous radiofrequency neurolysis for long-term pain relief in a four month period, per recipient, when all of the following are met: ◦ Low back or neck pain is suggestive of facet joint origin as documented in the recipient's history, physical and radiographic evaluations ◦ Pain has failed to respond to conservative	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
management (oral nonsteroidal anti-inflammatory medications, rest and limited activity, or physical therapy) as documented in the medical record ◦ A diagnostic temporary block and injections with local anesthetic of the facet nerve (medial branch block) under fluoroscopic guidance into the facet joint has resulted in at least fifty percent reduction in pain ◦ A minimum of six months has elapsed since prior percutaneous radiofrequency neurolysis treatment • Neuroplasty **Prior authorization is required.**	
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered partial hospitalization day.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Personal care services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services: Personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable members to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: ◦ Primary care physician services ◦ Physician specialist services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions)	$0 copay for Medicare-covered primary care physician (PCP) services (including telehealth services and urgently needed services). **Please Note:** If you use a PCP that is not printed on your ID card, you may incur a higher cost share or your claims may be denied. If you would like to change your PCP contact Member Services (phone numbers are printed on the back cover of this booklet). $0 copay for physician specialist services (including surgery second opinion, telehealth services, home

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services • This coverage is in addition to the telehealth services described below. For more details on your additional telehealth coverage, please review your Aetna Medicare Telehealth Coverage at AetnaMedicare.com/Telehealth. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ Members should contact their doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc, MinuteClinic Video Visit, or other provider that offers telehealth services covered under your plan. Members can access Teladoc at Teladoc.com/Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711). Members can find out if MinuteClinic Video Visits are available in their area at CVS.com/MinuteClinic/virtual-care/videovisit. • Some telehealth services including consultation, diagnosis, and treatment by a physician or	infusion professional services, and urgently needed services). $0 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including those for: • $0 copay for each primary care physician service • $0 copay for each physician specialist service • $0 copay for each mental health service (individual sessions) • $0 copay for each mental health service (group sessions) • $0 copay for each psychiatric service (individual sessions) • $0 copay for each psychiatric service (group sessions) • $0 copay for each urgently needed service $0 copay for each Medicare-covered dental service.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs In addition to Medicare-covered benefits, we also offer: • Additional non-Medicare covered podiatry services: up to twelve visits every year	$0 copay for each Medicare-covered podiatry visit. $0 copay for each non-Medicare covered podiatry visit.
Podiatry services (Medicaid) Additional coverage under the Medicaid portion of the plans benefits include medically necessary podiatry services as follows: • Up to 24 evaluation and management visits per recipient, per calendar year • Foot and nail care • Radiologic procedures specific to the foot, ankle, and lower extremity • Surgical procedures for disorders of the foot, ankle, and lower extremity **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Private duty nursing (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary private duty nursing (PDN) services provide medically necessary skilled nursing to members whose medical condition, illness, or injury requires the care to be delivered in their home or in the community. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Prostate cancer screening exams For men age 50 and older, covered services include the following – once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for each Medicare-covered digital rectal exam.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "**Vision Care**" later in this section for more detail. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered prosthetic device. $0 copay for Medicare-covered medical supplies.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered pulmonary rehabilitation service.
Regional perinatal intensive care centers (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services provided at Regional Perinatal Intensive Care Center. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Reproductive services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary obstetrical services, family planning services, sterilization, hysterectomy services and Therapeutic Abortion Services for terminations of pregnancies that are a result of rape or incest, or when the health of the woman is at risk. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services provided at a county health department, Rural Health Clinic, and/or federally qualified health center (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions	$0 - 20% coinsurance for each Medicare-covered kidney disease education session. $0 - 20% coinsurance for Medicare-

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "**Medicare Part B prescription drugs**." **Prior authorization may be required and is the responsibility of your provider.**	covered outpatient dialysis, self-dialysis training, certain home support services, and home dialysis equipment and supplies. Cost-sharing is charged for each inpatient stay. You pay $0 per stay for each medically necessary inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities, is considered a new admission. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Days covered: You are covered for up to 100 days per benefit period. A prior hospital stay is not required. We will only cover your stay if you meet certain Medicare guidelines and your stay is medically necessary. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily	$0 per stay for each Medicare-covered SNF stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits. In addition to Medicare-covered benefits, we also offer: • Additional individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. $0 copay for each non-Medicare covered smoking and tobacco use cessation visit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Specialized therapeutic services (Medicaid) Additional medically necessary specialized therapeutic services may be available under the Medicaid portion of the plan's benefits including comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders. **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Speech language pathology (Medicaid) Additional speech language pathology services may be available under the Medicaid portion of the plan's benefits. Speech-language pathology services provide for the evaluation and treatment of speech language disorders to remediate and maintain communication functioning, acquire a skill set, restore a skill set, and enhance communication. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Statewide inpatient psychiatric program (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary Statewide Inpatient Psychiatric services which provide extended residential psychiatric treatment, with the goal of facilitating successful return to treatment in a community-based setting. **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Supervised exercise therapy (SET) 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. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay for each Medicare-covered supervised exercise therapy service.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Transplant Services (Medicaid) Additional medically necessary transplant services may be available under the Medicaid portion of the plan's benefits including transplant services to replace bone marrow or vital solid organs that are no longer functional with organs or bone marrow from a human donor. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Transportation services (non-emergency) We cover 48 one-way trips every year***** (up to 60 miles each trip) Trip locations: • Plan Approved Health-related Locations via Taxi, Rideshare Services, Van Our plan has partnered with Access2Care to provide this benefit. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.** All trips are subject to a mileage limit unless pre-approved by the plan. Please contact Access2Care at 1-855-814-1699 for more details and at least 48 hours in advance to schedule a trip.	$0 copay for each transportation service.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. In addition to Medicare-covered benefits, we also offer: • Urgently needed services are covered worldwide.	$0 copay for each Medicare-covered urgent care facility visit. (See "**Physician/Practitioner services, including doctor's office visits**" for information about urgently needed services provided in a physician office.) $0 copay for each urgent care visit worldwide (i.e. outside the United States).

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) In addition to Medicare-covered benefits, we also offer: • Non-Medicare covered eye exams: one exam every year* • Follow-up diabetic eye exam*	$0 copay for services for the diagnosis and treatment of diseases and injuries of the eye. $0 copay for each Medicare-covered glaucoma screening. $0 copay for the initial diabetic eye exam each year. $0 copay for each follow up diabetic eye exam. $0 copay for Medicare-covered eyewear. $0 copay for each non-Medicare covered eye exam. Additional cost sharing may apply if you receive additional services during your visit.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Vision care - eyewear (non-Medicare covered) Non-Medicare covered prescription eyewear: • Contact lenses* • Eyeglasses (lenses and frames)* **Non-Medicare covered eyewear maximum benefit:** Plan pays up to $200 every year for non-Medicare covered prescription eyewear. You are responsible for any amount above the eyewear coverage limit. Network: iCare Our plan has partnered with iCare to provide your eyewear benefits. To locate a network provider, you may contact Member Services at the phone number on the back of your ID card or search the iCare online provider directory at myicarehealth.com/find-a-provider. If you choose not to use a network provider, your services will not be covered. Please note, refraction eye exams are only covered at an optometrist's office.	Non-Medicare covered eyewear: • Contact lenses: $0 copay • Eyeglasses (lenses and frames): $0 copay (one pair every year)

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Visual care (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary vision services as follows: Eyeglasses: • Two pairs of eyeglasses every 365 days for members under the age of 21 • One pair of frames every two years, and two lens every 365 days for members over the age of 21 Contacts: • Medicaid only covers contacts when the member has a documented medical condition where eyeglasses would not provide any benefit Medicaid visual care services provide eye examinations, diagnosis, treatment, and management related to ocular and adnexal pathology. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

Note: Cost-sharing is based on your level of Medicaid eligibility

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. $0 copay for a Medicare-covered EKG following the "Welcome to Medicare" preventive visit.
Wigs for hair loss related to chemotherapy This benefit is offered for hair loss as a result of chemotherapy. **Non-Medicare covered wigs maximum benefit:** Plan pays up to $400 every year for covered wigs. You are responsible for any amount above the wig coverage limit. Members can obtain the benefit by locating a local durable medical equipment (DME) provider on AetnaMedicare.com or pay for the services up front and submit a claim for reimbursement.	$0 copay for each covered item.

Note: Cost-sharing is based on your level of Medicaid eligibility

2022 FL Liberty DSNP Den 300 Mandatory
Schedule of Benefits

Our plan has partnered with Liberty Dental to provide your dental benefits. To locate a network provider, you may contact Member Services at (866) 610-0282 or search the Liberty Dental online

provider directory at libertydentalplan.com/AetnaMedicare. If you choose to use a provider outside of the network, the services you receive will not be covered.

Maximum Benefit					**None**
Deductible					**None**
CPT Code	**Description**	**Member Responsibility**	**Age Limits**	**Pre-Auth Required**	**Limitations**
Diagnostic Services					
D0120	Periodic oral evaluation	$0			2 (D0120) per calendar year; not within 6 months of D0150
D0140	Limited oral evaluation	$0			2 (D0140) every calendar year
D0145	Oral evaluation under age 3	$0	0-2		2 (D0145) every calendar year
D0150	Comprehensive oral evaluation	$0			1 (D0150) every 3 calendar years; not within 3 calendar years of D0120
D0180	Comprehensive periodontal evaluation	$0			1 (D0180) every 3 calendar years
D0190	Screening of a patient	$0	0-20		1 (D0190) every 6 months
D0191	Assessment of a patient	$0	0-20		1 (D0191) every 6 months

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D0210	Intraoral, complete series of radiographic images	$0			1 of (D0210, D0330) every 3 calendar years
D0220	Intraoral, periapical, first radiographic image	$0			6 of (D0220, D0230) every calendar year
D0230	Intraoral, periapical, each add'l radiographic image	$0			
D0240	Intraoral, occlusal radiographic image	$0			2 (D0240) every calendar year
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0			1 (D0250) every calendar year
D0251	Extra-oral posterior dental radiographic image	$0			3 (D0251) every calendar year
D0270	Bitewing, single radiographic image	$0			1 of (D0270-D0274) every calendar year
D0272	Bitewings, two radiographic images	$0			
D0273	Bitewings, three radiographic images	$0			
D0274	Bitewings, four radiographic images	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D0330	Panoramic radiographic image	$0			1 of (D0210, D0330) every 3 calendar years
D0340	2D cephalometric radiographic image, measurement and analysis	$0	0-20		1 (D0340) every calendar year
D0350	2D oral/facial photographic image, intra-orally/extra-orally	$0	0-20		1 (D0350) every calendar year
D0460	Pulp vitality tests	$0			3 (D0460) every 2 calendar years
Preventive Services					
D1110	Prophylaxis, adult	$0			2 of (D1110, D1120) every calendar year
D1120	Prophylaxis, child	$0	0-20		
D1206	Topical application of fluoride varnish	$0	0-20		1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	$0	0-20		
D1330	Oral hygiene instruction	$0	0-20		1 (D1330) every calendar year
D1351	Sealant, per tooth	$0	0-20		1 (D1351) per tooth every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D1354	Interim caries arresting medicament application, per tooth	$0	0-20		1 (D1354) per tooth every 6 months
D1355	Caries preventive medicament application, per tooth	$0	0-20		1 (D1355) per tooth every calendar year
D1510	Space maintainer, fixed, unilateral, per quadrant	$0	0-20		3 (D1510) every calendar year
D1516	Space maintainer, fixed, bilateral, maxillary	$0	0-20		2 (D1516) every calendar year
D1517	Space maintainer, fixed, bilateral, mandibular	$0	0-20		2 (D1517) every calendar year
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$0	0-20		1 (D1551) every calendar year
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$0	0-20		3 (D1552) every calendar year
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0	0-20		2 (D1553) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D1556	Removal of fixed unilateral space maintainer, per quadrant	$0	0-20		1 (D1556) every calendar year
D1557	Removal of fixed bilateral space maintainer, maxillary	$0	0-20		1 (D1557) every calendar year
D1558	Removal of fixed bilateral space maintainer, mandibular	$0	0-20		1 (D1558) every calendar year
D1575	Distal shoe space maintainer, fixed, per quadrant	$0	0-20		3 (D1575) every calendar year
D1999	Unspecified preventive procedure, by report	$0			1 (D1999) per date of service per office, covered for Personal Protective Equipment (PPE) – VAL
Restorative Services					
D2140	Amalgam, one surface, primary or permanent	$0			4 of (D2140-D2394) every calendar year
D2150	Amalgam, two surfaces, primary or permanent	$0			
D2160	Amalgam, three surfaces, primary or permanent	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D2161	Amalgam, four or more surfaces, primary or permanent	$0			
D2330	Resin-based composite, one surface, anterior	$0			
D2331	Resin-based composite, two surfaces, anterior	$0			
D2332	Resin-based composite, three surfaces, anterior	$0			
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$0			
D2390	Resin-based composite crown, anterior	$0			
D2391	Resin-based composite, one surface, posterior	$0			
D2392	Resin-based composite, two surfaces, posterior	$0			
D2393	Resin-based composite, three surfaces, posterior	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D2394	Resin-based composite, four or more surfaces, posterior	$0			
D2710	Crown, resin-based composite (indirect)	$0		Y	3 of (D2710-D2792, D6210-D6792) every calendar year; 1 per tooth every 5 calendar years
D2720	Crown, resin with high noble metal	$0		Y	
D2721	Crown, resin with predominantly base metal	$0		Y	
D2722	Crown, resin with noble metal	$0		Y	
D2740	Crown, porcelain/ceramic	$0		Y	
D2750	Crown, porcelain fused to high noble metal	$0		Y	
D2751	Crown, porcelain fused to predominantly base metal	$0		Y	
D2752	Crown, porcelain fused to noble metal	$0		Y	
D2753	Crown, porcelain fused to titanium and titanium alloys	$0		Y	
D2780	Crown, ¾ cast high noble metal	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D2781	Crown, ¾ cast predominantly base metal	$0		Y	
D2782	Crown, ¾ cast noble metal	$0		Y	
D2783	Crown, ¾ porcelain/ceramic	$0		Y	
D2790	Crown, full cast high noble metal	$0		Y	
D2791	Crown, full cast predominantly base metal	$0		Y	
D2792	Crown, full cast noble metal	$0		Y	
D2920	Re-cement or re-bond crown	$0			
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	$0			1 (D2928) every calendar year
D2930	Prefabricated stainless steel crown, primary tooth	$0	0-20		1 (D2930) every calendar year
D2931	Prefabricated stainless steel crown, permanent tooth	$0	0-20		1 (D2931) every calendar year
D2932	Prefabricated resin crown	$0	0-20		1 (D2932) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D2933	Prefabricated stainless steel crown with resin window	$0	0-20		1 (D2933) every calendar year
D2940	Protective restoration	$0	0-20		1 (D2940) every calendar year
D2950	Core Buildup, including any pins when required	$0			3 of (D2950-D2954) every calendar year; 1 per tooth every 5 calendar years
D2951	Pin retention, per tooth, in addition to restoration	$0			
D2952	Post and core in addition to crown, indirectly fabricated	$0			
D2953	Each additional indirectly fabricated post, same tooth	$0			
D2954	Prefabricated post and core in addition to crown	$0			
Endodontic Services					
D3110	Pulp cap, direct (excluding final restoration)	$0	0-20		1 (D3110) per tooth every calendar year
D3120	Pulp cap, indirect (excluding final restoration)	$0	0-20		

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D3220	Therapeutic pulpotomy (excluding final restoration)	$0	0-20		
D3221	Pulpal debridement, primary and permanent teeth	$0	0-20		
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$0	0-20		
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$0	0-20		
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	$0	0-20		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$0		Y	2 (D3310-D3330) every calendar year; 1 per tooth in a lifetime
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$0		Y	
D3331	Treatment of root canal obstruction; non-surgical access	$0	0-20		1 (D3331) per tooth every calendar year
D3333	Internal root repair of perforation defects	$0	0-20		1 (D3333) per tooth every calendar year
D3346	Retreatment of previous root canal therapy, anterior	$0		Y	2 (D3346-D3348) every calendar year; 1 per tooth in a lifetime
D3347	Retreatment of previous root canal therapy, premolar	$0		Y	
D3348	Retreatment of previous root canal therapy, molar	$0		Y	
D3351	Apexification/recalcification, initial visit	$0	0-20	Y	1 (D3351) per tooth every calendar year
D3352	Apexification/recalcification, interim medication replacement	$0	0-20	Y	1 (D3352) per tooth every calendar year
D3353	Apexification/recalcification, final visit	$0	0-20	Y	1 (D3353) per tooth every calendar year
D3410	Apicoectomy, anterior	$0	0-20	Y	1 (D3410) per tooth every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D3430	Retrograde filling, per root	$0	0-20		1 (D3430) per tooth every calendar year
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$0		Y	1 of (D4210, D4211) per quad every 2 calendar years
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$0		Y	
D4240	Gingival flap procedure, four or more teeth per quadrant	$0	0-20	Y	1 of (D4240, D4241) per quad every calendar year
D4241	Gingival flap procedure, one to three teeth per quadrant	$0	0-20	Y	
D4260	Osseous surgery, four or more teeth per quadrant	$0		Y	1 of (D4260, D4261) per quad every 2 calendar years
D4261	Osseous surgery, one to three teeth per quadrant	$0		Y	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$0			1 of (D4341, D4342) per quad every 2 calendar years

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$0			
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$0	0-20		1 (D4346) every calendar year
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	$0			1 (D4355) in a lifetime
D4910	Periodontal maintenance	$0			2 (D4910) every calendar year
D4921	Gingival irrigation, per quadrant	$0			2 (D4921) per quad every 2 calendar years
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	$0		Y	1 of (D5110-D5226, D6110-D6117) per arch every 5 calendar years
D5120	Complete denture, mandibular	$0		Y	
D5130	Immediate denture, maxillary	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D5140	Immediate denture, mandibular	$0		Y	
D5211	Maxillary partial denture, resin base	$0		Y	
D5212	Mandibular partial denture, resin base	$0		Y	
D5213	Maxillary partial denture, cast metal, resin base	$0		Y	
D5214	Mandibular partial denture, cast metal, resin base	$0		Y	
D5225	Maxillary partial denture, flexible base	$0		Y	
D5226	Mandibular partial denture, flexible base	$0		Y	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	$0		Y	1 of (D5284, D5286) per quad every 5 calendar years
D5286	Removable unilateral partial denture, one piece resin, per quadrant	$0		Y	
D5410	Adjust complete denture, maxillary	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D5411	Adjust complete denture, mandibular	$0			1 of (D5410-D5422) per arch every calendar year
D5421	Adjust partial denture, maxillary	$0			
D5422	Adjust partial denture, mandibular	$0			
D5511	Repair broken complete denture base, mandibular	$0			2 of (D5511, D5512) every calendar year
D5512	Repair broken complete denture base, maxillary	$0			
D5520	Replace missing or broken teeth, complete denture	$0			
D5611	Repair resin partial denture base, mandibular	$0			1 of (D5611, D5612) per arch every calendar year
D5612	Repair resin partial denture base, maxillary	$0			
D5621	Repair cast partial framework, mandibular	$0			1 of (D5621, D5622) per arch every calendar year
D5622	Repair cast partial framework, maxillary	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D5630	Repair or replace broken retentive clasping materials, per tooth	$0			
D5640	Replace broken teeth, per tooth	$0			
D5650	Add tooth to existing partial denture	$0			1 (D5650) every calendar year
D5660	Add clasp to existing partial denture, per tooth	$0			1 (D5660) every calendar year
D5730	Reline complete maxillary denture, direct	$0			1 of (D5730-D5761) per arch every 2 calendar years
D5731	Reline complete mandibular denture, direct	$0			
D5740	Reline maxillary partial denture, direct	$0			
D5741	Reline mandibular partial denture, direct	$0			
D5750	Reline complete maxillary denture, indirect	$0			
D5751	Reline complete mandibular denture, indirect	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D5760	Reline maxillary partial denture, indirect	$0			
D5761	Reline mandibular partial denture, indirect	$0			
D5810	Interim complete denture, maxillary	$0	0-20	Y	1 of (D5810-D5821) per arch every 5 calendar years
D5811	Interim complete denture, mandibular	$0	0-20	Y	
D5820	Interim partial denture, maxillary	$0	0-20	Y	
D5821	Interim partial denture, mandibular	$0	0-20	Y	
Implant Services					
D6010	Surgical placement of implant body, endosteal	$0		Y	2 of (D6010, D6013) every calendar year; 1 per tooth every 5 calendar years
D6013	Surgical placement of mini implant	$0		Y	
D6055	Connecting bar, implant supported or abutment supported	$0		Y	1 (D6055) every calendar year
D6056	Prefabricated abutment, includes modification and placement	$0		Y	2 of (D6056, D6057) every calendar year; 1 per tooth every 5 calendar years

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6057	Custom fabricated abutment, includes placement	$0		Y	
D6058	Abutment supported porcelain/ceramic crown	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6060	Abutment supported porcelain fused to base metal crown	$0		Y	
D6061	Abutment supported porcelain fused to noble metal crown	$0		Y	
D6063	Abutment supported cast metal crown, base metal	$0		Y	
D6064	Abutment supported cast metal crown, noble metal	$0		Y	
D6065	Implant supported porcelain/ceramic crown	$0		Y	
D6068	Abutment supported retainer, porcelain/ceramic FPD	$0		Y	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$0		Y	
D6073	Abutment supported retainer, cast metal FPD, base metal	$0		Y	
D6074	Abutment supported retainer, cast metal FPD, noble	$0		Y	
D6075	Implant supported retainer for ceramic FPD	$0		Y	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$0			2 (D6080) every calendar year
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$0			1 (D6081) per tooth every 2 calendar years
D6082	Implant supported crown, porcelain fused to predominantly base alloys	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6083	Implant supported crown, porcelain fused to noble alloys	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6086	Implant supported crown, predominantly base alloys	$0		Y	
D6087	Implant supported crown, noble alloys	$0		Y	
D6088	Implant supported crown, titanium and titanium alloys	$0		Y	
D6090	Repair implant supported prosthesis, by report	$0			1 (D6090) per site every calendar year
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$0			1 (D6091) every calendar year
D6092	Re-cement or re-bond implant/abutment supported crown	$0			1 (D6092) per site every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6093	Re-cement or re-bond implant/abutment supported FPD	$0			1 (D6093) per site every calendar year
D6095	Repair implant abutment, by report	$0			1 (D6095) per site every calendar year
D6096	Remove broken implant retaining screw	$0			1 (D6096) every calendar year
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$0		Y	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$0		Y	
D6100	Implant removal, by report	$0			1 (D6100) per tooth in a lifetime
D6101	Debridement of a peri-implant defect(s), surrounding single implant, including flap entry/closure	$0			1 (D6101) per tooth every 2 calendar years

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6102	Debridement and osseous contouring of a peri-implant defect(s) surrounding single implant, including flap entry/closure	$0			1 (D6102) per tooth every 2 calendar years
D6104	Bone graft at time of implant placement	$0		Y	2 (D6104) every calendar year
D6110	Implant/abutment supported removable denture, maxillary	$0		Y	1 of (D5110-D5226, D6110-D6117) per arch every 5 calendar years
D6111	Implant/abutment supported removable denture, mandibular	$0		Y	
D6112	Implant/abutment supported removable denture, partial, maxillary	$0		Y	
D6113	Implant/abutment supported removable denture, partial, mandibular	$0		Y	
D6114	Implant/abutment supported fixed denture, maxillary	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6115	Implant/abutment supported fixed denture, mandibular	$0		Y	
D6116	Implant/abutment supported fixed denture for partial, maxillary	$0		Y	
D6117	Implant/abutment supported fixed denture for partial, mandibular	$0		Y	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6122	Implant supported retainer for metal FPD, noble alloys	$0		Y	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	$0		Y	
D6191	Semi-precision abutment, placement	$0		Y	2 (D6191) every calendar year
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	$0		Y	2 of (D6058-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
Fixed Prosthodontic Services					
D6210	Pontic, cast high noble metal	$0		Y	3 of (D2710-D2792, D6210-D6792) every calendar year; 1 per tooth every 5 calendar years
D6211	Pontic, cast predominantly base metal	$0		Y	
D6212	Pontic, cast noble metal	$0		Y	
D6214	Pontic, titanium, and titanium alloys	$0		Y	
D6240	Pontic, porcelain fused to high noble metal	$0		Y	
D6241	Pontic, porcelain fused to predominantly base metal	$0		Y	
D6242	Pontic, porcelain fused to noble metal	$0		Y	
D6243	Pontic, porcelain fused to titanium and titanium alloys	$0		Y	
D6245	Pontic, porcelain/ceramic	$0		Y	
D6250	Pontic, resin with high noble metal	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6251	Pontic, resin with predominantly base metal	$0		Y	
D6252	Pontic, resin with noble metal	$0		Y	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$0		Y	
D6720	Retainer crown, resin with high noble metal	$0		Y	
D6721	Retainer crown, resin with predominantly base metal	$0		Y	
D6722	Retainer crown, resin with noble metal	$0		Y	
D6740	Retainer crown, porcelain/ceramic	$0		Y	
D6750	Retainer crown, porcelain fused to high noble metal	$0		Y	
D6751	Retainer crown, porcelain fused to predominantly base metal	$0		Y	
D6752	Retainer crown, porcelain fused to noble metal	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	$0		Y	
D6780	Retainer crown, ¾ cast high noble metal	$0		Y	
D6781	Retainer crown, ¾ cast predominantly base metal	$0		Y	
D6782	Retainer crown, ¾ cast noble metal	$0		Y	
D6783	Retainer crown, ¾ porcelain/ceramic	$0		Y	
D6784	Retainer crown ¾, titanium and titanium alloys	$0		Y	
D6790	Retainer crown, full cast high noble metal	$0		Y	
D6791	Retainer crown, full cast predominantly base metal	$0		Y	
D6792	Retainer crown, full cast noble metal	$0		Y	
D6985	Pediatric partial denture, fixed	$0	0-20	Y	1 (D6985) every calendar year
Oral & Maxillofacial Services					

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D7111	Extraction, coronal remnants, primary tooth	$0			1 (D7111) per tooth in a lifetime
D7140	Extraction, erupted tooth or exposed root	$0			8 of (D7140-D7241) every calendar year
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$0		Y	
D7220	Removal of impacted tooth, soft tissue	$0		Y	
D7230	Removal of impacted tooth, partially bony	$0		Y	
D7240	Removal of impacted tooth, completely bony	$0		Y	
D7241	Removal impacted tooth, complete bony, complication	$0		Y	
D7250	Removal of residual tooth roots (cutting procedure)	$0		Y	1 (D7250) per tooth in a lifetime
D7260	Oroantral fistula closure	$0		Y	1 (D7260) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D7261	Primary closure of a sinus perforation	$0		Y	1 (D7261) every calendar year
D7270	Tooth reimplantation and/or stabilization, accident	$0	0-20	Y	1 (D7270) every calendar year
D7280	Exposure of an unerupted tooth	$0	0-20		1 (D7280) every calendar year
D7283	Placement, device to facilitate eruption, impaction	$0	0-20	Y	1 (D7283) every calendar year
D7296	Corticotomy, one to three teeth or tooth spaces, per quadrant	$0	0-20	Y	1 of (D7296, D7297) per quad every calendar year
D7297	Corticotomy, four or more teeth or tooth spaces, per quadrant	$0	0-20	Y	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$0		Y	1 of (D7310-D7321) per quad every calendar year
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$0		Y	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$0		Y	
D7472	Removal of torus palatinus	$0		Y	1 (D7472) every calendar year
D7473	Removal of torus mandibularis	$0		Y	1 (D7473) every calendar year
D7510	Incision & drainage of abscess, intraoral soft tissue	$0			1 (D7510) every calendar year
D7520	Incision & drainage of abscess, extraoral soft tissue	$0			1 (D7520) every calendar year
D7880	Occlusal orthotic device, by report	$0	0-20	Y	1 (D7880) every calendar year
D7881	Occlusal orthotic device adjustment	$0	0-20	Y	1 (D7881) every calendar year
D7970	Excision of hyperplastic tissue, per arch	$0			1 (D7970) per arch every calendar year
Orthodontic Services					
D8070	Comprehensive orthodontic treatment of the transitional dentition	$0	0-20	Y	1 of (D8070-D8090) in a lifetime

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$0	0-20	Y	
D8090	Comprehensive orthodontic treatment of the adult dentition	$0	0-20	Y	
D8210	Removable appliance therapy	$0	0-20	Y	1 (D8210) in a lifetime
D8220	Fixed appliance therapy	$0	0-20	Y	1 (D8220) in a lifetime
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0	0-20	Y	1 (D8660) every calendar year
D8670	Periodic orthodontic treatment visit	$0	0-20	Y	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$0	0-20	Y	1 (D8680) per arch every calendar year
D8703	Replacement of lost or broken retainer, maxillary	$0	0-20	Y	1 (D8703) in a lifetime

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D8704	Replacement of lost or broken retainer, mandibular	$0	0-20	Y	1 (D8704) in a lifetime
Adjunctive General Services					
D9110	Palliative (emergency) treatment, minor procedure	$0	0-20		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0			
D9222	Deep sedation/general anesthesia, first 15 minute increment	$0		Y	7 of (D9222, D9223) per date of service
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$0		Y	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$0			
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$0		Y	7 of (D9239, D9243) per date of service

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$0		Y	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$0			
D9310	Consultation, other than requesting dentist	$0	0-20		1 (D9310) every calendar year
D9920	Behavior management, by report	$0	0-20		
D9944	Occlusal guard, hard appliance, full arch	$0		Y	1 of (D9944-D9946) per arch every 5 calendar years
D9945	Occlusal guard, soft appliance, full arch	$0		Y	
D9946	Occlusal guard, hard appliance, partial arch	$0		Y	
D9995	Teledentistry, synchronous; real-time encounter	$0			

CPT Code	Description	Member Responsibility	Age Limits	Pre-Auth Required	Limitations
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	$0			

LIMITATIONS AND EXCLUSIONS

1. Coverage is limited to those services set forth in the Schedule of Covered Benefits. If a service is not listed, it is not included and is not covered.
2. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
3. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to you by any municipality, county, or other political subdivision is not covered.
4. Treatment as a result of, civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime is not covered.
5. Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy to the extent permitted by federal or state statute is not covered.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services *not* covered by the plan

This section tells you what services are "excluded" by Medicare. Excluded means that the plan doesn't cover these services.

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan only under specific conditions.

We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Acupuncture		✓ Covered for chronic low back pain. Our plan provides some additional coverage for acupuncture as described in the *Medical Benefits Chart.*
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		✓ Custodial care may be available under the Medicaid portion of the plan's benefits. Members must meet specific criteria and custodial care services must be prior authorized. Please see the *Medical Benefits Chart* for more information.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals		✓ Our plan provides some coverage for home-delivered meals as described in the *Medical Benefits Chart*.
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Our plan provides some additional coverage for non-routine dental care as described in the *Medical Benefits Chart*.
Orthopedic shoes		✓ If 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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered. Our plan provides some additional coverage for routine chiropractic care as described in the *Medical Benefits Chart*. Additional services may be available under the Medicaid portion of the plan's benefits. Please see the *Medical Benefits Chart* for more information.
Routine dental care, such as cleanings, fillings or dentures.		✓ Our plan provides some coverage for preventive dental services as described in the *Medical Benefits Chart*.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Routine eye exams: Our plan provides some coverage for routine eye exams as described in the *Medical Benefits Chart*. Eyewear: Our plan provides some coverage for eyewear as described in the *Medical Benefits Chart*.
Routine foot care		✓ Our plan provides some coverage for routine foot care as described in the *Medical Benefits Chart*. Additional services may be available under the Medicaid portion of the plan's benefits. Please see the *Medical Benefits Chart* for more information.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Routine hearing exams: Our plan provides some coverage for routine hearing exams as described in the *Medical Benefits Chart*. Hearing aid fitting and evaluations: Our plan provides some coverage for hearing aid fitting and evaluations as described in the *Medical Benefits Chart*. Hearing aids: Our plan provides some coverage for hearing aids as described in the *Medical Benefits Chart*.
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Chapter 5

Using the plan's coverage for your Part D prescription drugs

Chapter 5. Using the plan's coverage for your Part D prescription drugs

How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you**.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs.**

In addition to your coverage for Part D drugs, Aetna Medicare Assure (HMO D-SNP) also covers some drugs under the plan's medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (Medical Benefits Chart, what is covered) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.3 (*What if you're in Medicare-certified hospice*). For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered).*

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. Please contact the state Medicaid agency listed in **Addendum A** at the back of this booklet for information about drugs covered under your Medicaid coverage.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider and Pharmacy Directory*, visit our website (AetnaMedicare.com/findpharmacy), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?
If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Provider and Pharmacy Directory*. You can also find information on our website at, AetnaMedicare.com/findpharmacy.

What if you need a specialized pharmacy?
Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail-order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as **"mail-order" drugs** in our Drug List.

Our plan's mail-order service allows you to order **up to a 100-day supply.**

To get order forms and information about filling your prescriptions by mail, visit our website or contact Member Services (phone numbers are printed on the back cover of this booklet).

Usually a mail-order pharmacy order will get to you in no more than 10 days. In the unlikely event that there is a significant delay with your mail-order prescription drug, our mail-order service will work with you and a network pharmacy to provide you with a temporary supply of your mail-order prescription drug.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by calling Member Services (phone numbers are on your member ID card).

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Member Services (phone numbers are printed on the back cover of this booklet).

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Member Services (phone numbers are printed on the back cover of this booklet).

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact

your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Member Services (phone numbers are printed on the back cover of this booklet).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling Member Services (phone number is on the back cover of this booklet).

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List (For tiers 1-4). (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail-order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs available through our plan's mail-order service are marked as **"mail-order" drugs** in our Drug List. Our plan's mail-order service allows you to order up to a 100-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network

retail or mail-order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).
- If you are traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.
- If you receive a Part D prescription drug, dispensed by an out-of-network institutional-based pharmacy, while you are in the emergency department, provider-based clinic, outpatient surgery or other outpatient setting.
- If you have not received your prescription during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence.

If you do need to go to an out-of-network pharmacy for any of the reasons listed above, the plan will cover up to a 10-day supply of drugs.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?
If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a *"List of Covered Drugs (Formulary)."* In this *Evidence of Coverage*, **we call it the "Drug List" for short**.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. Please contact the state Medicaid agency listed in Addendum A at the back of this booklet for information about drugs covered under your Medicaid

coverage.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- --*or*-- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.
- Drugs covered by Medicaid are not included on our Drug List. Information on how to find out about drugs covered under Medicaid is provided at the beginning of this section.

Section 3.2 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (AetnaMedicare.com/formulary). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you or has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting

approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3	Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (AetnaMedicare.com/formulary).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a

prescription drug you are currently taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

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

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.

- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year:**
  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**
  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- If you experience a change in your setting of care (such as being discharged or admitted to a long-term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with a temporary supply (at least a 30-day supply) for applicable drug(s).

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or add new restrictions to the brand name drug)**
  - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
  - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use until January 1 of the next year. Until that date, you probably won't see any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means neither Medicare nor Medicaid pays for these drugs.

We won't pay for the drugs that are listed in this section (except for certain excluded drugs covered under our enhanced drug coverage). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System. If the use is not supported by any of these references, then our plan cannot cover its "off-label use."

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Please contact the state

Medicaid agency listed in **Addendum A** at the back of this booklet for information about drugs covered under your Medicaid coverage. (Our plan covers certain drugs listed below through our enhanced drug coverage. More information is provided below.)

- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

We cover some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). These covered excluded drugs include select generic prescription vitamins, minerals, and erectile dysfunction medicine. These drugs and their prior authorization requirements and quantity limits are listed at the end of the Drug List (formulary) booklet. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in **Addendum A** at the back of this booklet.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for your covered prescription drug.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you**. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage.

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

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 31-day supply or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different

drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do.

Section 9.3 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription your opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or sickle cell disease, you are receiving hospice, palliative, end-of-life care or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) and other programs to help members manage their medications

We have programs that can help our members with complex health needs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 11 We send you reports that explain payments for your drugs

Section 11.1	We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs when you get your prescriptions filled or refilled at the pharmacy. In particular, we keep track of:

- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written summary called the *Part D Explanation of Benefits* (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take. The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1**. This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost-sharing for each prescription claim that may be available.

Section 11.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy using a discount card that is not part of our plan's benefit.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your

out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive a Part D Explanation of Benefits (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Chapter 6

What you pay for your Part D prescription drugs

How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

Chapter 7

Asking us to pay our share of a bill you have received for covered medical services or drugs

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment

Our network providers bill the plan directly for your covered services and drugs — you should not receive a bill for covered services or drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost for the service, we will

determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay more than your share of the cost.

- You only have to pay your cost-sharing amount when you get services covered by *our plan*. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. We do not allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service. For more information about "balance billing," go to Chapter 4 Section 1.3.
- Whenever you get a bill from a network providerthat you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the cost. You will need to submit paperwork for us to handle the reimbursement. Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.) Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (AetnaMedicare.com) or call Member

Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

Aetna Medicare
PO Box 981106
El Paso, TX 79998-1106

You must submit your medical claims to us within 12 months of the date you received the service, item, or Part B drug.

For Part D prescription drug claims: Mail your request for payment together with any bills or paid receipts to us at this address:

Aetna Medicare
PO Box 52446
Phoenix, AZ 85072-2446

You must submit your Part D prescription drug claims to us within 36 months of the date you received the service, item, or Part D drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1	We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement for our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for for our share of the cost of the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 9. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 5, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

When you get a drug through a patient assistance program offered by a drug manufacturer
Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1	We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. Many documents are also available in Spanish. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this *Evidence of Coverage* or with this mailing, or you may contact Member Services for additional information.

Sección 1.1	Debemos proporcionar información de una manera que funcione para usted (en idiomas distintos del inglés, en braille, en letra grande o en otros formatos alternativos, etc.)

Para obtener información sobre nosotros de una manera que sea conveniente para usted, llame al Departamento de Servicios para Miembros (en la contraportada de este documento encontrará impresos los números de teléfono).

Nuestro plan cuenta con personas y servicios de interpretación gratuitos disponibles para responder a las preguntas de los miembros con discapacidades y que no hablan inglés. Muchos documentos también están disponibles en español. También podemos proporcionarle información en braille, en tamaño de letra grande o en otros formatos alternativos, sin costo alguno, si lo necesita. Debemos proporcionarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información sobre nosotros de una manera que sea conveniente para usted, llame al Departamento de Servicios para Miembros (en la contraportada de este documento encontrará impresos los números de teléfono).

Si tiene alguna dificultad para obtener información sobre nuestro plan en un formato que sea

accesible y adecuado para usted, llámenos para presentar una queja ante el Departamento de Servicios para Miembros (en la contraportada de este documento encontrará impresos los números de teléfono). También puede presentar un reclamo ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. Encontrará la información de contacto en esta Evidencia de cobertura o se incluirá en este correo. También puede comunicarse con el Departamento de Servicios para Miembros para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time.* This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 5 tells what you can do.)

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.4	We must give you information about the plan, its network of providers, and your covered services

As a member of Aetna Medicare Assure (HMO D-SNP), you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial

condition. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the *Provider & Pharmacy Directory*.
  - For a list of the pharmacies in the plan's network, see the *Provider & Pharmacy Directory*.
  - For more detailed information about our providers and pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at AetnaMedicare.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs* (*Formulary*). These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care your Part D prescription drugs, see Chapter 7 of this booklet.

Section 1.5	We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

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

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to,* you can:

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

care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your SHIP. Contact information is in **Addendum A** at the back of this booklet.

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights
If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?
If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program (SHIP)**. For details about this organization and how to contact it, go to Chapter 2, Section 3 or **Addendum A** at the back of this booklet.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP.** For details about this organization and how to contact it, go to Chapter

2, Section 3 or **Addendum A** at the back of this booklet.

- You can contact **Medicare.**
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called **"coordination of benefits"** because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as

you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As an Aetna Medicare Assure (HMO D-SNP) member, you are responsible for these payments:
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most plan members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
    - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
    - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Member Services for help if you have questions or concerns**. We also welcome any suggestions you may have for improving our plan.
    - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 9

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

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

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Member Services (phone numbers are printed on the back cover of this booklet).
2. The type of problem you are having:
    - For some types of problems, you need to use the **process for coverage decisions and appeals**.
    - For other types of problems, you need to use the **process for making complaints**.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization
We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in **Addendum A** at the back of this booklet.

You can also get help and information from Medicare
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

You can get help and information from Medicaid
Contact information for your state's Medicaid agency can be found in **Addendum A** at the back of this booklet.

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for Medicare benefits or Medicaid benefits?

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to

use the Medicare process or the Medicaid process, please contact Member Services (phone numbers are printed on the back cover of this booklet).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem about Medicare benefits or Medicaid benefits?
(If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Member Services. Phone numbers for Member Services are printed on the back cover of this booklet.)

My problem is about **Medicare** benefits.

Go to the next section of this chapter, **Section 4, "Handling problems about your Medicare benefits."**

My problem is about **Medicaid** coverage.

Skip ahead to **Section 12** of this chapter, **"Handling problems about your Medicaid benefits."**

PROBLEMS ABOUT YOUR MEDICARE BENEFITS

SECTION 4 Handling problems about your Medicare benefits

Section 4.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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

To figure out which part of this chapter will help with your problem or concern about your **Medicare**

benefits, use this chart:

Is your problem or concern about your benefits or coverage?
(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1	Asking for coverage decisions and making appeals: the big picture

The process for asking for coverage decisions and appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which

means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us.

- In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal.
- In other situations, you will need to ask for a Level 2 Appeal.
- See **Section 6.4** of this chapter for more information about Level 2 Appeals.

If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 5.2	How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- You **can get free help** from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3	Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each

situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 8** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 9** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (SHIP) (**Addendum A** at the back of this booklet has the phone numbers for this program).

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 5 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services. This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - Chapter 9, Section 8: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
        - Chapter 9, Section 9: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon*. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 6.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 6.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 6.5** of this chapter.

Section 6.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your medical care.*

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- For a request **for a medical item or service, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
    - **For a request for a medical item or service, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
    - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For

more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or within 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making

complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or within 72 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

Section 6.3	Step-by-step: How to make a Level 1 Appeal (How to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us**. For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are making an appeal about your medical care*.
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 *(How to contact us when you are making an appeal about*

your medical care).

- If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 *(How to contact us when you are making an appeal about your medical care)*.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
    - If you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we decide we need to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
    - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process. Then an Independent Review Organization will review it. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

<u>Step 3:</u> If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 6.4 Step-by-step: How a Level 2 Appeal is done

- If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a

standard appeal at Level 2.

- If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the Independent Review Organization says yes to part or all of a request for a medical item or service,** we must:
  - authorize the medical care coverage **within 72 hours** or
  - provide the service **within 14 calendar days** after we receive the Independent Review Organization's decision for **standard requests** or
  - provide the service **within 72 hours** from the date the plan receives the Independent Review Organization's decision for **expedited requests.**
- **If the Independent Review Organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must:
  - authorize or provide the Medicare Part B prescription drug under dispute **within 72 hours** after we receive the Independent Review Organization's decision for **standard requests** or
  - **within 24 hours** from the date we receive the Independent Review Organization's decision for **expedited requests.**
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal,

which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). See Section 10 of this chapter for more information.
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.5	What if you are asking us to pay you back for our share of a bill you have received for medical care?

If you have already paid for a Medicaid service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the

payment for our share of the cost ofyour medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 6.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 5 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 7.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan*'s List of Covered Drugs (Formulary).* To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved

by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 *(Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 *(What you pay for your Part D prescription drugs)*.

Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a **"coverage determination."**

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 7.2** of this chapter.
If you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. Skip ahead to **Section 7.4** of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 7.4** of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 7.5** of this chapter.

Section 7.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5, Section 4).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug* first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 Specialty.
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 of this chapter tells how to make an appeal if we say no.

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

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a **"fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want**. Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5.2 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 7.2 and 7.3 of this chapter for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms
A "fast coverage decision" is called an "**expedited coverage determination.**"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 11 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In Section 7.6 of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In Section 7.6 of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2

of the appeals process, where it will be reviewed by an Independent Review Organization. In Section 7.6 of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 7.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "**fast appeal**."

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your Part D prescription drugs*).
- **If you are asking for a fast appeal, you may make your appeal in writing or you may**

call us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your Part D prescription drugs*).

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms
A "fast appeal" is also called an "**expedited redetermination.**"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 7.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.

- If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In Section 7.6 of this chapter, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In Section 7.6 of this chapter, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. In Section 7.6 of this chapter, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 7.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast" appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 Appeal **within 14 calendar days** after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested –**
    - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your

appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Benefits Chart (what is covered and what you pay*).

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 8.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 5.2 of this chapter tells how you can give written permission to someone else to act as your representative.)

- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 8.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**. Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see **Addendum A** at the back of this booklet).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

A "fast review" is also called an "immediate review."

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Addendum A** at the back of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**. (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4 of this chapter.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review**" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review"** is also called an **"immediate review"** or an "**expedited review**."

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the **"Detailed Notice of Discharge."** You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet.)

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the *first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead

of the standard deadlines.

Legal Terms
A "**fast review"** (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review.**" This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the "**IRE.**"

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal**, it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1	*This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words.*)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2	We will tell you in advance when your coverage will be ending

1. You receive a notice in writing. At least two days before our plan is going to stop covering your care, you will receive a notice.

- The written notice tells you the date when we will stop covering the care for you.
- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms
In telling you what you can do, the written notice is telling how you can request a "**fast-track appeal**." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)
The written notice is called the **"Notice of Medicare Non-Coverage."**

2. You will be asked to sign the written notice to show that you received it.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 5.2 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 9.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**. Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines**. The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Addendum A** at the back of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5 of this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the **"Detailed Explanation of Non-Coverage."**

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told**

you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal - and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 9.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast" review (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 10.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30**

calendar days after we receive the decision.

- **If the answer is no, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you.* Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 11.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?

Complaint	Example
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Complaint	Example
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a “fast coverage decision” or a “fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your

Complaint	Example
	case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 11.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 11.3 Step-by-step: Making a complaint

<u>Step 1:</u> Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Member Services can be reached at 1-866-409-1221 (TTY 711). Hours of operation are 8 AM to 8 PM, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- To use our grievance (complaint) process, you should call or send us your written complaint using one of the contact methods listed in Chapter 2: *Important Phone Numbers and Resources (How to contact us when you are making a complaint about your Part D prescription drugs* or *medical care).*
    - Please be sure you provide all pertinent information, including any supporting

documents you believe are appropriate. Your complaint must be received by us within 60 calendar days of the event or incident that resulted in you filing your complaint.
    - Your issue will be investigated by a member of our complaint team. If you submit your complaint verbally, we will inform you of the result of our review and our decision verbally or in writing. If you submit a verbal complaint and request your response to be in writing, we will respond in writing. If you send us a written complaint, we will send you a written response, stating the result of our review. Our notice will include a description of our understanding of your complaint and our decision in clear terms.
    - We must address your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if we justify a need for additional information and the delay is in your best interest.
    - You also have the right to ask for a fast "expedited" grievance. A fast "expedited" grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a fast "expedited" grievance if you disagree with:
        - Our plan to take a 14-calendar-day extension on an organization/coverage determination or reconsideration/redetermination (appeal); or
        - Our denial of your request to expedite an organization determination or reconsideration (appeal) for health services; or
        - Our denial of your request to expedite a coverage determination or redetermination (appeal) for a prescription drug.
- The fast "expedited" grievance process is as follows:
    - You or an authorized representative can call, fax, or mail your complaint and mention that you want the fast complaint or expedited grievance process. Call the phone number, fax, or write your complaint and send it to the address listed in Chapter 2*: Important Phone Numbers and Resources (How to contact us when you're making a complaint about your Part D prescription drugs* or *How to contact us when you are making a complaint about your medical care).* The fastest way to submit a fast complaint is to call or fax us. The fastest way to file a grievance is to call us. When we receive your complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-calendar-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will investigate your complaint and notify you of our decision within 24 hours.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 11.4	You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the *quality of care* you received by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization

for your state, look in **Addendum A** at the back of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about Aetna Medicare Assure (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12 Handling problems about your Medicaid benefits

Keep in mind that most of your benefits should be covered under your Medicare benefit plan. If there are benefits that are not covered under your Medicare benefit plan, you will still have access to those benefits through your Medicaid coverage with Aetna. Aetna has a contract with the State of Florida to cover most of your Medicaid benefits as well as your Medicare benefits.

If you have a problem or concern about your covered Medicaid benefits, you can contact Aetna.

When any of your Medicaid services are denied, the appeal process is different than the one used for Medicare-based services.

For Medicaid only services, we have to follow the Medicaid process for complaints, appeals and grievances. We want you to let us know right away if you have any questions, complaints or problems with your Medicaid covered services or the care you receive. In this section we will explain how you can contact us with your concerns.

If you have a problem with your Medicaid covered services, you can file a complaint, a grievance or request an appeal.

Complaints

State law allows you to make a complaint if you have any problems with us or the services you are receiving. The state has also set the rules for making a complaint. We have to follow the state rules on handling your complaint. We have to treat you fairly and cannot disenroll you from our plan or treat you differently.

A complaint is when you are unhappy with something with our plan. (It's less formal than a grievance.) When you have a complaint, you may call or write to us. Call Member Services at 1-866-409-1221 Monday – Friday, 8 AM to 8 PM.
Or write to:

Aetna Medicare Grievances
PO Box 14834
Lexington, KY 40512

We will resolve your complaint by the close of business the next business day or change it to a formal grievance.

Grievances

A grievance is when you make a complaint about us. It can also be about a provider and/or a service. These complaints may be about:

- Quality-of-care issues
- Wait times during provider visits
- The way your providers or others act or treat you
- Unclean provider offices
- Not getting the information you need

You can file a grievance by calling, faxing or writing to us. You can call Member Services at 1-866-409-1221 Monday – Friday, 8 AM to 8 PM, or you can write to us at the following address:

Aetna Medicare Grievances
PO Box 14834
Lexington, KY 40512

You can fax us at 1-724-741-4956.

You can file your grievance yourself. Or you can have someone file it for you. (This includes your PCP or another provider.) If at any time you need help filing one, call us.

If you wish to have someone act for you, you must send us a signed statement. (It should be signed by you.) The statement must say you are allowing this person to represent you. To help you with this, we have an Appointment of Representative form on our website at AetnaMedicare.com. You can use this form to allow someone to act for you.

You can file your grievance at any time.

Within (5) five business days of receiving your grievance, we will mail you a letter letting you know that we received your grievance. We will send you another letter with our decision about your grievance no later than (90) ninety calendar days after we received the grievance.

You also have the right to request a 14-day extension if you have additional information to support your grievance. If it is in your best interest, the plan also has the right to extend the review of your grievance. If we extend the time we need to review your grievance, we will call you to let you know that additional time is needed. We will also send you a letter that tells you why we need the additional time within two calendar days of the decision to extend our review.

Medicaid Only Benefit Appeals Process

Standard Appeals

If the plan denies your request for a service that is a Medicaid-only benefit, you, or a provider acting on your behalf with your permission, can request an appeal.

An appeal is a request you can make when you don't agree with a decision we made about your care. Or it can be for if we take too long to make a care decision. You can ask for an appeal if we:

- Deny or limit a service you or your doctor asks us to approve
- Reduce, suspend or stop services you've been getting that we already approved
- Do not pay for the health care services you get
- Fail to give services in the required time frame
- Fail to give you a decision on an appeal you already filed in the required time frame
- Don't agree to let you see a doctor who is not in our network and you live in a rural area or in an area with limited doctors

You will get a letter from us when any of these actions occur. It's called a Notice of Adverse Benefit Determination or NABD. You can file an appeal if you do not agree with our decision.

You may file your appeal by calling or writing to us within 60 calendar days from the date on the Notice of Adverse Benefit Determination. To file the appeal by calling us, call 866-241-0365 Monday – Friday, 8:00 am – 8:00 pm. If you call in your appeal, you must follow up with a written, signed appeal letter within 10 calendar days of calling in your appeal.

Send your written appeals here:

For appeal requests for pharmacy medications:

Aetna Medicare Part D Appeals
PO Box 14579
Lexington, KY 40512

You can fax your appeal to: 1-724-741-4954

For appeal requests for medical items or services and Medicare Part B prescription drugs:

Aetna Medicare Part C Appeals
PO Box 14067
Lexington, KY 40512

You can fax your appeal to: 1-724-741-4953

You can file your appeal yourself. Or you can have someone file it for you. (This includes your PCP or another provider.) We must have your written permission before someone can file an appeal for you. To have your provider appeal on your behalf, you must appoint the provider as your representative. If you need help filing your appeal, you can always call 866-241-0365, Monday – Friday 8:00 am – 8:00 pm.

We will send you a letter within five business days of getting your appeal to let you know that we received it. We will then review the appeal and send you a Notice of Plan Appeal Resolution (NPAR) letter within 30 calendar days. The Notice of Plan Appeal Resolution letter will explain the information we reviewed and the decision we made about your appeal request.

Fast or Expedited Appeals

There may be times when you or your provider will want us to make a faster appeal decision. This could be because you or your provider feels that waiting 30 calendar days could seriously harm your health. If so, you can ask for a fast or expedited appeal.

To request a fast appeal, you or your provider can call 866-241-0365 for a medical appeal and 866-241-0365 for a pharmacy appeal, or fax us at 1-724-741-4953 for a medical appeal and 1-724-741-4954 for a pharmacy appeal. If your request for a fast appeal is filed verbally, written notice is not needed.

If we decide you need a fast appeal, we will call you with our decision. We will do this within 72 hours after receiving your fast appeal. We will also send you a Notice of Plan Appeal Resolution (NPAR) letter with our decision. If you ask for a fast appeal and we decide that one is not needed, we will:

- Change the appeal to the time frame for a standard decision (30 calendar days)
- Call you the same day we decide a fast appeal is not needed to tell you about our denial of your fast appeal request
- Follow up with a written letter within two calendar days
- Tell you over the phone and in writing that you may file a grievance about the denial of your fast appeal request

Additional Information

You or someone appealing for you can give us more information if you feel it will help your appeal. You can do this at any time during the appeal process.

For a standard appeal, you can ask us for up to 14 more calendar days to provide more information. If we think it's in your best interest, we may ask for 14 more calendar days to make a decision on a standard appeal. If we need more time, we will call you to tell you that additional time is needed. We will also send you a letter within two calendar days telling you why we are requesting more time.

Additional Appeals Assistance

If you are not happy with our appeal decision, you have a couple of options available to you. You can request a Medicaid Fair Hearing.

Medicaid Fair Hearing

You can ask for a Medicaid Fair Hearing (MFH). You must have completed the plan's appeal process before you can ask for a Medicaid Fair Hearing. You can request a MFH within 120 calendar days of receiving the Notice of Plan Appeal Resolution from the plan.

To request a Medicaid Fair Hearing review of the plan's appeal decision, submit a request for review to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906

Phone: 877-254-1055 (toll-free)
Fax: 239-338-2642
Email: MedicaidHearingUnit@ahca.myflorida.com

You have to complete the plan's appeal decision process before submitting a request fot a Medicaid Fair Hearing.

Continuation of Benefits During the Appeals Process

You can ask that we continue to cover your medical services while your appeal is pending for a decision.

To continue medical services for a pending appeal decision you must meet the following conditions:

- You must file your appeal with us within 10 calendar days of our mailing the Notice of Adverse Benefit Determination (NABD) to you or on or before the first day that the service will be reduced, suspended or stopped, whichever is later
- Your appeal involves an action we are taking to reduce, suspend or stop a service we had already approved
- The service must have been ordered by an authorized provider
- The original time period covered by the approval we gave has not yet ended
- You need to ask for a continuation of benefits

If you meet all of the conditions as outlined above, we will continue your benefits until one of the following happens:

- You withdraw your appeal;
- 10 days pass after we send you the notice of resolution of the appeal against you, unless you have asked for a Medicaid Fair Hearing with continuation of benefits in those 10 days; or
- The time period or service limits of the previously authorized service have been met

Continuation of Benefits during Medicaid Fair Hearings

To ask for benefits to continue during a Medicaid Fair hearing, you must:

- Request a fair hearing within ten (10) calendar days after the Notice of Plan Appeal Resolution is mailed, or on or before the intended effective date of the proposed action, whichever is later

The plan will not suspend, terminate or reduce services until a decision is rendered after the Medicaid Fair Hearing.

What if the Medicaid Fair Hearing officer rules against the plan's action? If we did not provide the services you wanted during the appeal, we will approve them no later than 72 hours from the date when we receive notice to change the appeal decision. If you did receive the services during the appeal, we will pay for them.

What if the officer rules in favor of the plan's action? In this case, you may have to pay for services you received.

Chapter 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan

Ending your membership in Aetna Medicare Assure (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1	You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March

- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
    - If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without "creditable" prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in **Addendum A** at the back of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If

you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
  - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 4 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.3	You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **When will your membership end?** Your membership will end on the first day of the month

after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4	In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period.**

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - Usually, when you have moved
  - If you have Medicaid
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions
  - If we violate our contract with you
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
  - **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

  Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan

- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
  - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 4 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

  Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5	Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2022*** handbook.
  - Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1	Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate

Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Aetna Medicare Assure (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Aetna Medicare Assure (HMO D-SNP) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan ◦ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. ◦ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Aetna Medicare Assure (HMO D-SNP) when your coverage in Original Medicare begins.

For questions about your FL State Medicaid benefits, contact the Medicaid office. See **Addendum A** at the back of this booklet for the contact information. Ask how joining another plan or returning to Original Medicare affects how you get your FL State Medicaid coverage.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Aetna Medicare Assure (HMO D-SNP), it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends**. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Aetna Medicare Assure (HMO D-SNP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Aetna Medicare Assure (HMO D-SNP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. Our plan will continue to cover your Medicare benefits for a grace period of up to six (6) months if you lose Medicaid eligibility. This grace period begins the first day of the month after we learn of your loss of eligibility and communicate that to you. If at the end of the six (6) month grace period you have not regained Medicaid and you have not enrolled in a different plan, we will disenroll you from our plan and you will be enrolled back in Original Medicare.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Aetna Medicare Assure (HMO D-SNP) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

Chapter 11

Legal notices

Chapter 11. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Aetna Medicare Assure (HMO D-SNP), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program

is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179)*. You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

The plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the federal statutes governing the Medicare Program. Your Medicare Advantage plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers' compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your Medicare Advantage plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

As outlined herein, in these situations, your Medicare Advantage plan may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your Medicare Advantage plan shall be subrogated to stand in the place of all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your Medicare Advantage plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your Medicare Advantage plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your Medicare Advantage plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. Your Medicare Advantage plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your Medicare Advantage plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Medicare Advantage plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your Medicare Advantage plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist your Medicare Advantage plan in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing the plan for benefits paid relating to the injury, illness or condition as well as for the plan's reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 4 Notice about recovery of overpayments

If the benefits paid by this *Evidence of Coverage*, plus the benefits paid by other plans, exceeds the total amount of expenses, Aetna has the right to recover the amount of that excess payment from among one or more of the following: (1) any person to or for whom such payments were made; (2) other Plans; or (3) any other entity to which such payments were made. This right of recovery will be exercised at Aetna's discretion. You shall execute any documents and cooperate with Aetna to secure its right to recover such overpayments, upon request by Aetna.

SECTION 5 National Coverage Determinations

Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services. When we receive coverage updates from Medicare, called National Coverage Determinations, we'll post the coverage updates on our website at AetnaMedicare.com. You can also call Member Services to obtain the coverage updates that have been posted for the benefit year.

SECTION 6 Independent Contractors

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

Chapter 12

Definitions of important words

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Aetna Medicare Assure (HMO D-SNP), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,050 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example,

20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an

employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage **(EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Health Maintenance Organizations (HMO) – A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Independent Practice Associations (IPA) – Negotiate with insurers to provide services for insureds on a flat fee or retainer basis. They allow physicians to remain independent while still collaborating with other doctors to achieve best practices and negotiate with insurers as a group.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $4,430.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to

state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See **Addendum A** at the back of this booklet for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network – A group of doctors, hospitals, pharmacies, and other health care experts contracted by our plan to provide covered services to its members (see Chapter 1, Section 3.2). Network providers are independent contractors and not agents of our plan.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Non-Medicare Covered Services – Services that are not normally covered when you have Original Medicare. These are usually extra benefits you may receive as a member of a Medicare Advantage plan.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs.

(See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Cost-Sharing - Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See **Addendum A** at the back of this booklet for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality,

safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Addendum A – Important Contact Information for State Agencies

	Quality Improvement Organizations (QIO)
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**KEPRO** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751, TTY: 711 Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM keproqio.com

	State Medicaid Office
FL	**Florida Agency for Health Care Administration- Division of Medicaid** 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308 1-850-412-4000, TTY: 1-800-955-8771 Monday–Friday 8:00 AM to 5:00 PM ahca.myflorida.com/Medicaid/index.shtml

	State Health Insurance Assistance Program (SHIP)
FL	**Serving Health Insurance Needs of Elders (SHINE)** 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000 1-800-963-5337, TTY: 1-800-955-8770 Monday–Friday 8:00 AM to 5:00 PM floridashine.org/

	State AIDS Drug Assistance Programs (ADAP)
FL	**Florida AIDS Drug Assistance Program (ADAP)** HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399 1-800-352-2437, 850-245-4422, TTY: 1-888-503-7118 Monday–Friday 8:00 AM to 5:00 PM floridahealth.gov/diseases-and-conditions/aids/adap/

	Ombudsman
FL	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Florida's Long-Term Care Ombudsman Program** 4040 Esplanade Way, Tallahassee, FL 32399-7000 1-888-831-0404, 850-414-2323, TTY: 711 Monday–Friday 8:00 AM to 5:00 PM ombudsman.elderaffairs.org/

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Aetna Medicare Assure (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL 	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY 	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX 	1-866-759-4415
WRITE 	Aetna Medicare PO Box 7405 London, KY 40742
WEBSITE 	AetnaMedicare.com

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **Addendum A** at the back of this *Evidence of Coverage* booklet.

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