aetna®

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of Aetna Medicare Value Plus (PPO)

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-833-570-6670 or the number on your member ID card for additional information. (TTY users call 711.) Hours are 8 AM to 8 PM, 7 days a week. This call is free.

This plan, Aetna Medicare Value Plus (PPO), is offered by AETNA HEALTH AND LIFE INSURANCE COMPANY. (When this *Evidence of Coverage* says "we," "us," or "our," it means AETNA HEALTH AND LIFE INSURANCE COMPANY. When it says "plan" or "our plan," it means Aetna Medicare Value Plus (PPO).)

This document is available for free in Spanish. Este documento está disponible de forma gratuita en español.
This document is available for free in other formats such as braille, large print or other alternate formats upon request.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network can change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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OMB Approval 0938-1051 (Expires: August 31, 2026)

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CHAPTER 1:
Get started as a member

SECTION 1 You're a member of Aetna Medicare Value Plus (PPO)

Section 1.1 You're enrolled in Aetna Medicare Value Plus (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health and your drug coverage through our plan, Aetna Medicare Value Plus (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Aetna Medicare Value Plus (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Aetna Medicare Value Plus (PPO) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get 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 the months you're enrolled in Aetna Medicare Value Plus (PPO) between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Aetna Medicare Value Plus (PPO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Aetna Medicare Value Plus (PPO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States

Section 2.2 Plan service area for Aetna Medicare Value Plus (PPO)

Aetna Medicare Value Plus (PPO) is only available to people who live in our plan service area. To stay a member of our plan you must continue to live in our service area. The service area is described below.

Our service area includes these counties in **Texas**: Austin, Brazoria, Brazos, Chambers, Colorado, Fort Bend, Grimes, Hardin, Jasper, Jefferson, Liberty, Madison, Matagorda, Montgomery, Newton, Polk, San Jacinto, Tyler, Walker, Waller, Washington, Wharton.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-833-570-6670 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

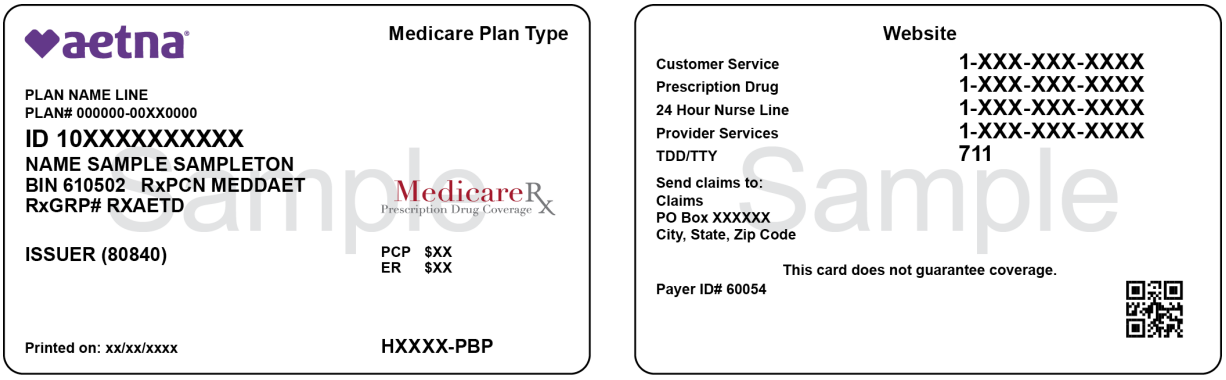
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Aetna Medicare Value Plus (PPO) if you're not eligible to stay a member of our plan on this basis. Aetna Medicare Value Plus (PPO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Aetna Medicare Value Plus (PPO) 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 Medicare approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-833-570-6670 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 *Provider & Pharmacy Directory*

The *Provider & Pharmacy Directory* (AetnaMedicare.com/findprovider and AetnaMedicare.com/findpharmacy) lists our current network providers, durable medical equipment suppliers, and network pharmacies. **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.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover

services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using our plan for your medical services*) for more specific information.

Get the most recent list of providers and suppliers on our website at **AetnaMedicare.com/findprovider**.

Network pharmacies are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Provider & Pharmacy Directory* to find the network pharmacy that you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

The *Provider & Pharmacy Directory* also shows which pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

Get the most recent list of pharmacies is available on our website at **AetnaMedicare.com/findpharmacy**.

If you don't have a *Provider & Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Member Services at **1-833-570-6670** (TTY users call **711**). Requested paper *Provider & Pharmacy Directories* will be mailed to you within 3 business days.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Aetna Medicare Value Plus (PPO). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Aetna Medicare Value Plus (PPO) Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit **AetnaMedicare.com/formulary** or call Member Services at **1-833-570-6670** (TTY users call **711**).

SECTION 4 Summary of Important Costs for 2026

	Your costs in 2026
Monthly plan premium* *Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	$4.80
Deductible	$0
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered services. (Go to Chapter 4 Section 1 for details.)	From network providers: $6,750 From in-network and out-of-network providers combined: $10,100
Primary care office visits	$0 per visit
Specialist office visits	$65 per visit

	Your costs in 2026
Inpatient hospital stays	$440 per day, days 1-6; $0 per day, days 7-90; $0 copay for additional days for each medically necessary covered inpatient stay.
Part D drug coverage deductible (Go to Chapter 6 Section 4 for details.)	$615 (Tiers 3–5) except for covered insulin products and most adult Part D vaccines.

	Your costs in 2026
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** *Standard cost-sharing:* You pay $2 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Drug Tier 2:** *Standard cost-sharing:* You pay $12 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Drug Tier 3:** *Standard cost-sharing:* You pay 22% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay 22% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 4:** *Standard cost-sharing:* You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 5:** *Standard cost-sharing:* You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay 25% of the total cost.

	Your costs in 2026
	You pay no more than $35 per month supply of each covered insulin product on this tier. **Catastrophic Coverage Stage:** • During this payment stage, you pay nothing for your covered Part D drugs.

Your costs can include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

In some situations, your plan premium could be less
There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate document, 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 document, call Member Services at **1-833-570-6670** (TTY users call **711**) and ask for the LIS Rider.

Section 4.1 Plan Premium

As a member of our plan, you pay a monthly premium. For 2026, the monthly premium for Aetna Medicare Value Plus (PPO) is **$4.80**.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook, the section called *2026 Medicare Costs*. Download a copy from the Medicare website (**medicare.gov/medicare-and-you**) or order a printed copy by phone at 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment

period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly or quarterly premium. When you first enroll in Aetna Medicare Value Plus (PPO), we let you know the amount of the penalty.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.46. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly

Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **www.Medicare.gov/health-drug-plans/part-d/basics/costs**.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for our prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your plan premium

There are 5 ways you can pay your plan premium.

Option 1: Pay by check
If you did not select a payment option on our enrollment application at the time you enrolled in our plan, we will automatically set you up on the **invoice method** so that you can make your payments by check. You may decide to pay your monthly plan premium to us by check using our invoice method. Please make your checks payable to our plan (which is indicated 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 slip 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.

Option 2: Paying at a CVS Pharmacy
If a barcode is printed on your invoice, you may pay your monthly plan premium at any retail CVS location (excluding CVS pharmacies in Target and Schnucks stores). 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 toward your premium and you will need to confirm the amount on

the credit/debit card machine. You will then be able to pay the premium along with any other items you are purchasing with cash or credit/debit 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.

Option 3: Paying by automatic withdrawal
You may decide to pay your monthly plan premium by an automatic payment from your checking/savings account or credit/debit card by the Electronic Fund Transfer (EFT) option.

- To enroll in this program online, go to **AetnaMedicare.com/PayBill**. Select the following deduction options: "on due date" and "amount due".
- Alternatively, you may contact Member Services or complete and return the authorization form located on your premium invoice. Your plan premium will be automatically deducted from your bank 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. By selecting this payment option, you will no longer receive an invoice.

Option 4: Using your credit/debit card or via e-check
You may pay your plan premium each month by using your credit/debit card or checking account. Please remember all premiums are due on the first of the month.

- Pay each month or set up a recurring payment selecting your choice of withdrawal date and amount online at **AetnaMedicare.com/PayBill**.
- You may also call Member Services to make a payment over the phone. You will continue to receive an invoice if you set up this payment option.

Option 5: Have plan premiums deducted from your monthly Social Security check

Changing the way you pay your plan premium.
If you decide to change how you pay our plan premium it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure our plan premium is paid on time. To change your payment method, call Member Services at **1-833-570-6670** (TTY users call **711**).

If you have trouble paying your plan premium
If you have trouble paying your plan premium on time, call Member Services at **1-833-570-6670** (TTY users call **711**) to see if we can direct you to programs that will help with your costs.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

If you become eligible for Extra Help or if you lose your eligibility for Extra Help during the year, the part of our plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premium. If you lose eligibility for Extra Help during the year, you'll need to start paying the full monthly premium. Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at **1-833-570-6670** (TTY users call **711**).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't have to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at **1-833-570-6670** (TTY users call **711**). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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) are 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are 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 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, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 Aetna Medicare Value Plus (PPO) contacts

For help with claims, billing, or member card questions, call or write to Aetna Medicare Value Plus (PPO) Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	1-833-570-6670 or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services at 1-833-570-6670 (TTY users call 711) also has free language interpreter services 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 14088 Lexington, KY 40512
Website	AetnaMedicare.com

How to ask for a coverage decision or appeal about your medical care
A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	1-833-570-6670 or the number on your member ID card 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 14079 Lexington, KY 40512
Website	AetnaMedicare.com

Coverage Decisions for Part D 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.

Coverage Decisions for Part D Drugs – Contact Information	
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 14095 Lexington, KY 40512
Website	AetnaMedicare.com

Appeals for Medical Care – Contact Information	
Call	1-800-282-5366 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
Website	Aetna.com/medicare/contact-us/appeals-grievances.html

Appeals for Part D Drugs – Contact Information	
Call	1-866-241-0357 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 make 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	1-833-570-6670 or the number on your member ID card 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	To submit a complaint about Aetna Medicare Value Plus (PPO) directly to Medicare, go to **www.Medicare.gov/my/medicare-complaint**.

Complaints about Part D Drugs – Contact Information	
Call	1-833-570-6670 or the number on your member ID card 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	To submit a complaint about Aetna Medicare Value Plus (PPO) directly to Medicare, go to **www.Medicare.gov/my/medicare-complaint**.

How to ask us to pay our share of the cost for medical care or a drug you got
If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

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

Payment Requests for Part D Drugs – Contact Information	
Write	Aetna Pharmacy Management PO Box 52446 Phoenix, AZ 85072-2446
Website	AetnaMedicare.com

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about Aetna Medicare Value Plus (PPO). **To submit a complaint to Medicare**, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Refer to **Appendix A** at the back of this document for the name and contact information of the State Health Insurance Assistance Program in your state.

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

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

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Refer to **Appendix A** at the back of this document for the name and contact information of the Quality Improvement Organization in your state.

The Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It's not connected with our plan.

Contact the Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for 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, contact Social Security to let them know.

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

Social Security – Contact Information	
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 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **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+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicaid Savings Programs, contact your state Medicaid agency. Refer to **Appendix A** at the back of this document for the name and contact information for the Medicaid agency in your state.

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare
Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- You can send your evidence documentation to us using any of the following contact methods:

Best Available Evidence – Contact Information	
Write	Best Available Evidence PO Box 14076 Lexington, KY 40512
Fax	1-888-665-6296
Email	BAE/LISmailbox@aetna.com

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Member Services at **1-833-570-6670** (TTY users call **711**) if you have questions.

What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?
Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP in your state (telephone numbers are in **Appendix A** at the back of this document).

NOTE: To be eligible for the ADAP in your state, people 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 change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call your state ADAP contact. (Refer to **Appendix A** at the back of this document for the name and contact information of the ADAP in your state.)

State Pharmaceutical Assistance Programs
Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

Refer to **Appendix A** at the back of this document for the name and contact information of the State Pharmaceutical Assistance Program in your state.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this

payment option, call Member Services at **1-833-570-6670** (TTY users call **711**) or visit **Medicare.gov**.

Medicare Prescription Payment Plan – Contact Information	
Call	**1-833-570-6670** or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services at **1-833-570-6670** (TTY users call **711**) also has free language interpreter services 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.
Write	Aetna Medicare PO Box 7 Pittsburgh, PA 15230
Website	**AetnaMedicare.com**

SECTION 8 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	**1-877-772-5772** Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number aren't free.
Website	**https://RRB.gov**

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at **1-833-570-6670** (TTY users call **711**) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (**1-800-633-4227**) with questions about your Medicare coverage under this plan. TTY users call **1-877-486-2048**.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **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 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 their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Aetna Medicare Value Plus (PPO) must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Aetna Medicare Value Plus (PPO) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
    - The providers in our network are listed in the *Provider & Pharmacy Directory* (**AetnaMedicare.com/findprovider**).
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
    - Note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?
As a member of our plan, you do not have to choose a network PCP, **however**, **we strongly encourage**

you to choose a PCP and let us know who you chose. Your PCP can help you stay healthy, treat illnesses and coordinate your care with other health care providers.

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?
Your PCP will provide most of your care, and when you need more specialized services, they will coordinate your care 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
- 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.

What is the role of the PCP in making decisions about or obtaining prior authorization (PA), if applicable?
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 to choose a 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. You can change your PCP (as explained later in this section) for any reason, and at any time, by contacting Member Services.

How to change your PCP
You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP or you'll pay more for covered services.

To change your PCP, call Member Services **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.

Section 2.2 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. For example:

- 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?
If you choose to select a PCP, 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. Your PCP may refer you to a specialist, but you can go to any specialists in our network *without* a referral.

Prior authorization process
In some cases, your PCP, 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, treating provider, or you as the member. Services and items requiring prior authorization are listed in the *Medical Benefits Chart* in Chapter 4, Section 2.

Prior authorization is not required for covered services received out-of-network; however, if we later determine that the services you received were not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. You or your doctor may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary by calling Member Services.

When a specialist or another network provider leaves our plan
We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving your plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care

complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher**. Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they are eligible to participate in Medicare.
- You don’t need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary (go to Chapter 9, Section 4). This is important because:
  - Without a pre-visit coverage decision, and if our plan later determines that the services aren’t covered or weren’t medically necessary, our plan may deny coverage and you’ll be responsible for the entire cost. If we say we won’t cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 7).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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 (and, if you’re a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that’s 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 don’t need to get approval or a referral first from your PCP. You don’t need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they’re not part of our network.
- **As soon as possible, make sure 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 your member ID card).

Covered services in a medical emergency

Our plan covers worldwide services outside 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. Be sure to get a copy of all your medical records from your emergency care or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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.

Our plan covers worldwide services outside 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. Be sure to get a copy of all your medical records from your emergency care or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.

Section 3.3 Get 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're still entitled to care from our plan.

Visit **AetnaMedicare.com** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

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

If you paid more than our plan cost sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Aetna Medicare Value Plus (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services not covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use 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 Medical services 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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the

rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us that you're in a qualified clinical trial, then you're only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must to submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study
Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at: **www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf**. You can also call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

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

Section 6.1 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'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get 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're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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 only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

As a member of Aetna Medicare Value Plus (PPO), we will transfer ownership of certain DME items. In Original Medicare, there is a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the

purchase price is met, you can use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up.

Call Member Services at **1-833-570-6670** (TTY users call **711**) to find out about the requirements you must meet and the documentation you will need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?
If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Aetna Medicare Value Plus (PPO) 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 Value Plus (PPO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?
Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months you rent the equipment. For the remaining 24 months the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Aetna Medicare Value Plus (PPO). This section also gives information about medical services that aren't covered and also explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** 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 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is **$6,750**. This is the most you pay during the calendar year for covered plan services you got from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D drugs, and services from out-of-network providers don't count toward this in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay **$6,750** for covered services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premiums and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is **$10,100**. This is the most you pay during the calendar year for covered plan services you got from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D drugs don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay **$10,100** for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay 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 Providers aren't allowed to balance bill you

As a member of Aetna Medicare Value Plus (PPO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get 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.
    - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Member Services at **1-833-570-6670** (TTY users call **711**).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Aetna Medicare Value Plus (PPO) covers and what you pay out-of-pocket for each service. (Part D drug coverage is covered in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
    - Covered services that need approval in advance to be covered as in-network services are marked by a note in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on

what type of provider you receive the services from:
  - 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.
  - 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.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at **Medicare.gov** or ask for a copy by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - Anemia
  - Autoimmune disorders limited to:
    - Dermatomyositis
    - Polyarteritis nodosa
    - Polymyalgia rheumatica
    - Polymyositis
    - Psoriatic arthritis
    - Rheumatoid arthritis
    - Scleroderma
    - Systemic lupus erythematosus
  - Cancer
  - Cardiovascular disorders limited to:
    - Cardiac arrhythmias
    - Coronary artery disease
    - Peripheral vascular disease
    - Valvular heart disease
  - Chronic alcohol use disorder and other substance use disorders (SUDS)
  - Chronic and disabling mental health conditions limited to:
    - Anxiety disorders
    - Bipolar disorders
    - Eating disorders
    - Major depressive disorders

    - Paranoid disorder
    - Post-traumatic stress disorder (PTSD)
    - Schizophrenia
    - Schizoaffective disorder
- Chronic conditions that impair vision, hearing (deafness), taste, touch and smell
- Chronic gastrointestinal disease limited to:
    - Chronic liver disease
    - Hepatitis B
    - Hepatitis C
    - Irritable bowel syndrome
    - Inflammatory bowel disease
    - Non-alcoholic fatty liver disease (NAFLD)
    - Pancreatitis
- Chronic heart failure
- Chronic hyperlipidemia
- Chronic hypertension
- Chronic kidney disease (CKD) limited to:
    - CKD not requiring dialysis
    - CKD requiring dialysis/End-stage renal disease (ESRD)
- Chronic lung disorders limited to:
    - Asthma
    - Chronic bronchitis
    - Chronic obstructive pulmonary disease (COPD)
    - Cystic fibrosis
    - Emphysema
    - Pulmonary fibrosis
    - Pulmonary hypertension
- Chronic pain
- Conditions associated with cognitive impairment limited to:
    - Alzheimer's disease
    - Disabling mental illness associated with cognitive impairment
    - Intellectual disabilities and developmental disabilities
    - Mild cognitive impairment
    - Traumatic brain injuries
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges and require similar services including the following:
    - Arthritis
    - Limb loss
    - Paralysis
    - Spinal cord injuries
    - Stroke
- Dementia
- Diabetes mellitus
- HIV/AIDS

- Immunodeficiency and immunosuppressive disorders
- Neurologic disorders limited to:
  - Amyotrophic lateral sclerosis (ALS)
  - Chronic fatigue syndrome
  - Epilepsy
  - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
  - Fibromyalgia
  - Huntington's disease
  - Multiple sclerosis (MS)
  - Parkinson's disease
  - Polyneuropathy
  - Spinal cord injuries
  - Spinal stenosis
  - Stroke-related neurologic deficit
- Overweight, obesity, and metabolic syndrome
- Post-organ transplantation care
- Severe hematologic disorders limited to:
  - Aplastic anemia
  - Chronic venous thromboembolic disorder
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
- Stroke

- For more detail, go to the *Special Supplemental Benefits for the Chronically Ill* row in the below Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

Important information regarding the services listed below in the Medical Benefits Chart:

If you receive services from:	If your plan services include:	You will pay:
A primary care provider (PCP) or specialist and get more than one covered service during the single visit: *A clinic visit cost share may apply based on the role of the attending provider (PCP or specialist).*	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services **and** the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

If you receive services from:	If your plan services include:	You will pay:
An outpatient facility and get more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services **and** the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay in-network	What you pay out-of-network
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our 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.	40% coinsurance 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 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 disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. 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: *This benefit is continued on the next page.*	$65 copay for each Medicare-covered acupuncture visit.	40% coinsurance for each Medicare-covered acupuncture visit.

Covered Service	What you pay in-network	What you pay out-of-network
Acupuncture for chronic low back pain *(continued)* • a master's 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.		
Aetna® Medicare Extra Benefits Card You get an Aetna Medicare Extra Benefits Card to help pay for certain everyday expenses. On this card you get: A CVS Over-the-Counter (OTC) Wallet with a quarterly benefit amount (allowance). See the CVS Over-the-Counter (OTC) Wallet section in Chapter 4 for more details. Qualifying members may also be eligible for an additional Wallet on the Aetna Medicare Extra Benefits Card. See the **Special Supplemental Benefits Chart** section in Chapter 4 for more details. **Important:** • The Aetna Medicare Extra Benefits Card does not replace your member ID card. • If you received an Extra Benefits Card in 2025 and have not changed plans, you **will not** receive a new card for the 2026 plan year. Be sure to keep your card. • If you are a new member or were not enrolled in a plan with an Extra Benefits Card in 2025, you will receive a new card in the mail. You should receive the card before your plan starts. It will include instructions on how to activate and use the card.	There is no coinsurance, copayment, or deductible for the Aetna Medicare Extra Benefits Card.	There is no coinsurance, copayment, or deductible for the Aetna Medicare Extra Benefits Card.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Aetna® Medicare Extra Benefits Card *(continued)* • If you change plans, you may receive a new card. Hold onto your current card and do not throw it away unless you get a new card. • It is your responsibility to ensure that Aetna has the most up-to-date mailing address on file. This includes your apartment number, if applicable. Aetna is not responsible for misdirected, lost, or undelivered mail. • Keep your card safe and secure. Aetna is not responsible for unused funds due to lost or stolen cards. If you need a replacement card, please call **1-844-428-8147** (**TTY: 711**) to request a new card. In the meantime, you can access certain benefits by visiting **CVS.com/Aetna**. • The card can only be used at participating retailers that accept Visa®. Find a participating retailer by visiting **CVS.com/Aetna**. • The card cannot be used to pay for prescription drugs or products such as alcohol, tobacco, cannabis, firearms, and gift cards. • The card can only be used to pay for products and services incurred while enrolled in the plan. • Aetna is not responsible for unused funds due to personal circumstances in which you cannot use your benefit amount (e.g., hospital stay, travel, etc.). • Unused funds will be forfeited. There will be no exceptions to apply unused funds due to a lost or stolen card, personal circumstances, or failure to provide your accurate mailing address to Aetna. For more information you can call **1-844-428-8147** (**TTY: 711**) 7 days a week, 8 AM - 8 PM local time excluding federal holidays or visit **CVS.com/Aetna**.		
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means	$340 copay for each Medicare-covered one-way trip via ground ambulance.	$340 copay for each Medicare-covered one-way trip via ground ambulance. 20% coinsurance for each Medicare-covered

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Ambulance services *(continued)* of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be 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 all non-emergency transportation, including fixed wing, rotary wing, and ground ambulance services.**	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.	one-way trip via air ambulance. Ground or air ambulance cost sharing is not waived if you are admitted to the hospital.
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. (See **Outpatient diagnostic tests and therapeutic services and supplies** for more information.)	$0 copay for an annual routine physical exam.	40% coinsurance for an annual routine physical exam.
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.	40% coinsurance for the annual wellness visit.

Covered Service	What you pay in-network	What you pay out-of-network
Bone mass measurement For qualified people (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.	40% coinsurance 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 aged 40 and older • Clinical breast exams once every 24 months **Prior authorization may be required and is the responsibility of your provider.**	There is no coinsurance, copayment, or deductible for covered screening mammograms. $0 copay for each diagnostic mammogram.	40% coinsurance for covered screening mammograms. 40% coinsurance for each diagnostic mammogram.
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. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$20 copay for each Medicare-covered cardiac rehabilitation service. $20 copay for each Medicare-covered intensive cardiac rehabilitation service.	40% coinsurance for each Medicare-covered cardiac rehabilitation service. 40% coinsurance for each Medicare-covered intensive cardiac rehabilitation service.
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.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	40% coinsurance for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	40% coinsurance for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include:	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic	40% coinsurance for Medicare-covered preventive Pap and pelvic exams.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Cervical and vaginal cancer screening *(continued)* • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	exams.	
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	$15 copay for each Medicare-covered chiropractic visit.	40% coinsurance for each Medicare-covered chiropractic visit.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. **Prior authorization may be required and is the responsibility of your provider.**	Cost sharing for this service will vary depending on individual services provided under the course of the treatment.	Cost sharing for this service will vary depending on individual services provided under the course of the treatment.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, *This benefit is continued on the next page.*	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy. Diagnostic colonoscopy: $0 copay **Note:** If a polyp is removed or a biopsy is performed during a Medicare-covered screening or diagnostic colonoscopy, the polyp removal and associated pathology will be covered at $0 copay.	40% coinsurance for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy. Diagnostic colonoscopy is subject to the **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** cost-sharing amount. If you have had polyps removed during a previous colonoscopy or have a condition that is monitored via colonoscopy (such as a prior history of colon cancer), ongoing colonoscopies are considered diagnostic.

Covered Service	What you pay in-network	What you pay out-of-network
Colorectal cancer screening *(continued)* payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Twice per calendar year. • Screening Guaiac-based fecal occult blood test for patients 45 years and older. Twice per calendar year. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		**Note:** 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 subject to the outpatient surgery cost sharing. (See **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** for more information.)
CVS Over-the-Counter (OTC) Wallet You get a CVS Over-the-Counter (OTC) Wallet with a $15 quarterly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card to pay for:	There is no coinsurance, copayment, or deductible for the CVS Over-the-Counter (OTC) Wallet.	The Extra Benefits Card can only be used at participating retail locations and online or by phone through CVS.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
CVS Over-the-Counter (OTC) Wallet *(continued)* • Approved over-the-counter (OTC) health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. This benefit includes certain nicotine replacement therapies. • The allowance can only be used to purchase approved OTC products in-store at CVS® retail locations (excluding locations inside other stores) and online at **CVS.com/Aetna** or by phone at **1-844-428-8147** (**TTY:** **711**). Your quarterly benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each calendar quarter. Calendar quarters begin in January, April, July, and October. Be sure to use the full benefit amount. Any unused benefit amount will not roll over into the next plan year. There are no exceptions to request additional or unused funds to be added to your card. **Important:** All products and services are subject to tax (depending on your state). Your card balance will be used to cover taxes. If there are not enough funds on your card to cover the taxes, they will be your responsibility to cover. For more information on the Aetna Medicare Extra Benefits Card, see the Aetna Medicare Extra Benefits Card section in Chapter 4.		
Dental services In general, preventive dental services (such as cleanings, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover the following non-Medicare covered benefits: **Preventive dental services (non-Medicare covered):** For a list of covered preventive services, see the dental schedule. *This benefit is continued on the next page.*	$65 copay for each Medicare-covered dental service. **Preventive dental services (non-Medicare covered):** For details on cost-sharing for covered preventive services, see the dental schedule. **Comprehensive dental services (non-Medicare covered):** For details on cost-sharing for covered comprehensive services, see the dental schedule.	40% coinsurance for each Medicare-covered dental service. **Preventive dental services (non-Medicare covered):** For details on cost-sharing for covered preventive services, see the dental schedule. **Comprehensive dental services (non-Medicare covered):** For details on cost-sharing for covered comprehensive services, see the dental schedule.

Covered Service	What you pay in-network	What you pay out-of-network
Dental services *(continued)* **Comprehensive dental services (non-Medicare covered):** For a list of covered comprehensive services, see the dental schedule. You get an **annual benefit amount (allowance)** of $1,000 for covered comprehensive dental services. Covered preventive dental services do not count toward your annual benefit amount. Covered services will be paid to the provider up to the annual benefit amount (allowance). If you exceed the benefit amount for covered comprehensive services, you will be responsible for those costs and will not be reimbursed. This dental benefit offers both in-network and out-of-network dental coverage. Out-of-network dentists are not required to accept the plan's payment as payment in full for covered services. Out-of-network claims are reimbursed up to the plan's allowable amount for each covered service. That means your plan will pay its portion for covered services. If your out-of-network provider charges over the allowable amount for a covered service, you may receive a bill and you will be responsible for payment of that bill. For the lowest potential out-of-pocket costs on covered dental services, see a provider in our dental network. Dental services you receive from an out-of-network provider are subject to any in-network benefit maximums, limitations and/or exclusions that may apply. See dental schedule for more details. To find a provider in the dental network, visit **AetnaMedicare.com/H3288-018** or call the Member Services number on your member ID card. **Note:** Your dental network is different than your medical network. *Amounts you pay for preventive dental services do not apply to your in-network or combined maximum out-of-pocket amount. *Amounts you pay for comprehensive dental services do not apply to your in-network or combined maximum out-of-pocket amount.		

Covered Service	What you pay in-network	What you pay out-of-network
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.	40% coinsurance for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these 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. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	40% coinsurance 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Important Blood Glucose Meter (BGM) Information:** We exclusively cover blood glucose meters and test strips manufactured and distributed by Roche/Accu-Chek and TRUE/Trividia meters currently available. Meters and test strips produced by other manufacturers may be covered if medically necessary, such as large font	0% - 20% coinsurance for each Medicare-covered supply. • 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies. • 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization. • Coinsurance for pharmacy diabetic supplies is determined by tier in the plan's formulary guide. $0 copay for Medicare-covered diabetic shoes and inserts. $0 copay for Medicare-covered diabetes	0% - 20% coinsurance for each Medicare-covered supply to monitor blood glucose. • 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies. • 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization. • Coinsurance for pharmacy diabetic supplies is determined by tier in the plan's formulary guide. 20% coinsurance for Medicare-covered diabetic shoes and inserts.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Diabetes self-management training, diabetic services and supplies *(continued)* or talking meters for the visually impaired. Medical exceptions for the visually impaired may be covered with an approved prior authorization. • Blood glucose meters and other testing supplies (e.g., lancing devices, lancets and test strips) can be obtained with a prescription from a network pharmacy or Durable Medical Equipment (DME) provider. • Medical diabetic supplies; blood glucose meters, lancets and control solutions are covered under your medical coverage. • Pharmacy diabetic supplies (e.g., alcohol swabs, lancets, 2x2 gauze, needles and syringes) are covered under your prescription drug coverage. These diabetic supplies can be found on your plan's formulary guide. • Prior authorization are required for more than one blood glucose meter per year and/or test strips in excess of 100 strips for a one month supply and may be required for diabetic shoes and inserts. Prior authorization is the responsibility of your provider.	self-management training.	$0 copay for Medicare-covered diabetes self-management training.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't 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. We cover all medically necessary DME covered by Original Medicare. Your provider must provide a prescription for covered DME and obtain prior authorization if required. In Original Medicare, there is a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the purchase price is met, you can	0% - 20% coinsurance for each Medicare-covered durable medical equipment (DME) item. • 0% coinsurance for continuous glucose monitors. • 20% coinsurance for all other Medicare-covered DME items.	40% coinsurance for each Medicare-covered durable medical equipment (DME) item.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Durable medical equipment (DME) and related supplies *(continued)* use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up. Under certain limited circumstances we will transfer ownership of the DME item to you. The most recent list of network DME pharmacies and suppliers is available on our website at **AetnaMedicare.com/dme**. Continuous glucose monitors (CGMs) and supplies are available through network DME providers. For a list of DME providers, visit **Aetna.com/dsepublicContent/assets/pdf/en/DME_National_Provider_Listing.pdf**. Dexcom and FreeStyle Libre continuous glucose monitors and sensors are available without a prior authorization at network pharmacies with a history of insulin usage in the past 6 months. For those not using insulin as part of their treatment plan, prior authorization will be required for monitors and sensors. Prior authorization for monitors and sensors may apply as well as exception requests if exceeding quantity limits that align to Medicare coverage guidance. **Prior authorization may be required and is the responsibility of your provider.**		
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 (and, if you're a pregnant woman, loss of an unborn child), 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's quickly getting worse. Cost sharing for necessary emergency services *This benefit is continued on the next page.*	$130 copay for emergency care. Cost sharing is waived if you are admitted to the hospital within 24 hours. $130 copay for emergency care worldwide (i.e., outside the United States). Cost sharing is waived if you are admitted to the hospital. $340 copay for one-way emergency ambulance services worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.	$130 copay for emergency care. Cost sharing is waived if you are admitted to the hospital within 24 hours. $130 copay for emergency care worldwide (i.e., outside the United States). Cost sharing is waived if you are admitted to the hospital. $340 copay for one-way emergency ambulance services worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.

Covered Service	What you pay in-network	What you pay out-of-network
Emergency care *(continued)* you get out-of-network is the same as when you get these services in-network. In addition to Medicare-covered benefits, we also offer: • Emergency care (worldwide) • Emergency ambulance services (worldwide) $250,000 annual maximum benefit for worldwide emergency, emergency ambulance, and urgently needed care. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.
Fitness: Annual fitness membership You are covered for a basic membership to any SilverSneakers® participating fitness facility. If you do not reside near a participating facility, or prefer to exercise at home, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers. Included with your basic SilverSneakers membership, you will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self-help, and staying connected. These classes can be accessed online by visiting **SilverSneakers.com**. To get started, you will need your SilverSneakers ID number. Please visit **SilverSneakers.com** or call SilverSneakers at **1-855-627-3795** (**TTY: 711**) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers. **Important:** You get a basic membership at any participating SilverSneakers location. Facility	$0 copay for basic health club membership/fitness classes at participating SilverSneakers locations.	$0 copay for at-home fitness kits ordered through SilverSneakers. There are no out-of-network facilities available for this benefit.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Fitness: Annual fitness membership *(continued)* amenities may vary by participating location including but not limited to hours, days and class types.		
Health and wellness education programs **24-Hour Nurse Line:** You can talk to a registered nurse 24 hours a day, 7 days a week on the 24/7 Nurse Line. They can help with health-related questions when your doctor is not available. Call 1-855-493-7019 (**TTY:** 711). The registered nurse staff cannot diagnose, prescribe or give medical advice. If you need urgent or emergency care, call 911 and/or your doctor immediately. * While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics. **Health education:** You can meet with a certified health educator or other qualified health professional to learn about health and wellness topics like: diabetes management, nutrition counseling, asthma education, and more. You have the option to meet one-on-one, in a group, or virtually. Ask your provider for information on how these services may help you.	$0 copay for 24-Hour Nurse Line benefit. $0 copay for health education.	The in-network provider must be used for the 24-Hour Nurse Line benefit. Health education is included in your plan.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from 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: You get an annual benefit amount (allowance) of $500 per ear, every year. This benefit amount can only be used to purchase hearing aids through a NationsHearing® network provider. If the cost is over the benefit amount, you pay the difference.	$65 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 per ear, per year (two hearing aids every year).	40% coinsurance for each Medicare-covered hearing exam. 40% coinsurance for each non-Medicare covered routine hearing exam. $0 copay for each non-Medicare covered hearing aid fitting/evaluation. Hearing aids must be purchased through NationsHearing. Coverage will not be provided for hearing aids purchased from a non-participating provider.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Hearing services *(continued)* Routine hearing exam: We have teamed up with NationsHearing to provide your hearing exam. You can schedule your hearing exam with a NationsHearing provider by calling 1-877-225-0137 (**TTY:** 711). Representatives are available 8:00 am to 8:00 pm local time, 7 days a week, with the exception of holidays. **Note:** If you get an exam with a provider outside of the NationsHearing network, you may be responsible for a cost share. Hearing aids: We have teamed up with NationsHearing to provide your hearing aids. Your hearing aid benefit amount can only be used to purchase hearing aids through a NationsHearing network provider. The benefit amount is applied to the hearing aids at the time of purchase. If the cost is more than the benefit amount, you pay the difference. **Note:** If you receive a hearing exam from a provider outside of the NationsHearing network and need hearing aids, that provider must call NationsHearing at 1-877-226-8992 (**TTY:** 711) to get your hearing aids. They will provide the exam results and help schedule an appointment for you at a Nations provider to get your hearing aids and fittings. *Amounts you pay for hearing aids do not apply to your in-network or combined maximum out-of-pocket amount.		
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	40% coinsurance for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get 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	$0 copay for each Medicare-covered home health service. 0% - 20% coinsurance for	40% coinsurance for each Medicare-covered home health service. 40% coinsurance for each

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Home health agency care *(continued)* homebound, which means leaving home is a major effort. Covered services include, but aren't 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.**	each Medicare-covered durable medical equipment (DME) item. • 0% coinsurance for continuous glucose monitors. • 20% coinsurance for all other Medicare-covered DME items.	Medicare-covered durable medical equipment (DME) item.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person 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 aren't limited to: • Professional services, including nursing services, furnished in accordance with our 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 provider 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.) **Note:** 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.	You will pay the cost sharing that applies to primary care provider 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.) **Note:** 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.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that	When you enroll in a Medicare-certified hospice program, your hospice services and your	When you enroll in a Medicare-certified hospice program, your hospice services and your

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Hospice care *(continued)* you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. 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 When you're admitted to a hospice you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare.	Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Aetna Medicare Value Plus (PPO). Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.	Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Aetna Medicare Value Plus (PPO). Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Hospice care *(continued)* **For services that are covered by Aetna Medicare Value Plus (PPO) but not covered by Medicare Part A or B:** Aetna Medicare Value Plus (PPO) will continue to cover plan-covered services that aren't covered under Part A or Part B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4 . **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. 0% - 20% coinsurance for all other vaccines covered under Medicare Part B. • Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	0% coinsurance for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. 40% coinsurance for all other vaccines covered under Medicare Part B.
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're formally admitted to the hospital with a doctor's order. The day before	$440 per day, days 1-6; $0 per day, days 7-90; $0 copay for additional days for each medically necessary covered inpatient stay. Cost	40% per stay for each medically necessary covered inpatient stay.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Inpatient hospital care *(continued)* you're discharged is your last inpatient day. Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge. Covered services include but aren't 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-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 Value Plus (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.	sharing is charged for each medically necessary covered 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'd pay at a network hospital.	Cost sharing is charged for each medically necessary covered 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'd pay at a network hospital.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Inpatient hospital care *(continued)* • Blood – including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • 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're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. **Prior authorization may be required and is the responsibility of your provider.** *Amounts you pay for blood do not apply to your in-network or combined maximum out-of-pocket amount.		
Inpatient services in a psychiatric hospital 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 doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Cost sharing is not charged on the day of discharge. **Prior authorization may be required and is the responsibility of your provider.**	$300 per day, days 1-6; $0 per day, days 7-90 for each medically necessary covered inpatient stay. Cost sharing is charged for each medically necessary covered 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.	40% per stay for each medically necessary covered inpatient stay. Cost sharing is charged for each medically necessary covered 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.

Covered Service	What you pay in-network	What you pay out-of-network
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your skilled nursing facility benefits, or if the skilled nursing facility or inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • 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.**	$0 copay for Medicare-covered primary care provider (PCP) services (including nationally contracted walk-in clinic services and urgently needed services). $65 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). $40 copay for each Medicare-covered diagnostic procedure and test. $0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing. $0 copay for each Medicare-covered lab service. $325 copay for each Medicare-covered CT scan. $325 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 - $50 copay for each Medicare-covered x-ray.	40% coinsurance for Medicare-covered primary care provider (PCP) services (including telehealth services and urgently needed services). 40% coinsurance for Medicare-covered physician specialist services (including surgery second opinion, telehealth services, home infusion professional services, and urgently needed services). 40% coinsurance for each Medicare-covered diagnostic procedure and test. 40% coinsurance for each Medicare-covered lab service. 40% coinsurance for each Medicare-covered CT scan and Medicare-covered diagnostic radiology services other than CT scans. 40% coinsurance for each Medicare-covered x-ray. 40% coinsurance for each Medicare-covered therapeutic radiology service. 40% coinsurance for Medicare-covered medical supplies. 40% coinsurance for each Medicare-covered prosthetic and orthotic device. 40% coinsurance for each
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay *(continued)*	• $0 copay for services provided by your primary care provider in their office. • $50 copay for services performed by a provider other than your primary care provider. 20% coinsurance for each Medicare-covered therapeutic radiology service. 0% - 20% coinsurance for Medicare-covered medical supplies. • 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies. 20% coinsurance for each Medicare-covered prosthetic and orthotic device. $50 copay for each Medicare-covered physical and speech therapy service. $50 copay for each Medicare-covered occupational therapy service.	Medicare-covered physical and speech therapy service. 40% coinsurance for each Medicare-covered occupational therapy service.
Medical nutrition therapy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered	40% coinsurance for members eligible for Medicare-covered medical nutrition therapy

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Medical nutrition therapy *(continued)* 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 the first year you get 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 get 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.	medical nutrition therapy services.	services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people 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.	$0 copay for the Medicare-covered MDPP benefit.
Medicare Part B 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 get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that *This benefit is continued on the next page.*	$35 copay for insulin. Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin and plan level deductibles do not apply. 0% - 20% coinsurance for chemotherapy drugs. • Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. 0% - 20% coinsurance for all other drugs covered under Medicare Part B.	$35 copay for insulin. Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin and plan level deductibles do not apply. 40% coinsurance for chemotherapy drugs. 40% coinsurance for all other drugs covered under Medicare Part B. Part B drugs may be subject to step therapy requirements.

Covered Service	What you pay in-network	What you pay out-of-network
Medicare Part B drugs *(continued)* could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral	• Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. Part B drugs may be subject to step therapy requirements.	
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Medicare Part B drugs *(continued)* medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This 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 most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D drugs through our plan is explained in Chapter 6. **Prior authorization may be required and is the responsibility of your provider.**		
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.	40% coinsurance for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:	$50 copay for each Medicare-covered opioid use disorder treatment service.	40% coinsurance for each Medicare-covered opioid use disorder treatment service.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Opioid treatment program services *(continued)* • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist 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.**		
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't 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. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests **Prior authorization may be required and is the responsibility of your provider.** *Amounts you pay for blood do not apply to your in-network or combined maximum out-of-pocket amount.	$0 - $50 copay for each Medicare-covered x-ray. • $0 copay for services provided by your primary care provider in their office. • $50 copay for services performed by a provider other than your primary care provider. 20% coinsurance for each Medicare-covered therapeutic radiology service. 0% - 20% coinsurance for Medicare-covered medical supplies. • 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies.	40% coinsurance for each Medicare-covered x-ray. 40% coinsurance for each Medicare-covered therapeutic radiology service. 40% coinsurance for Medicare-covered medical supplies. 40% coinsurance for each Medicare-covered lab service. 40% coinsurance for Medicare-covered and non-Medicare covered blood services. 40% coinsurance for each Medicare-covered CT scan and Medicare-covered diagnostic radiology services other than CT scans. 40% coinsurance for each Medicare-covered diagnostic procedure and test.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Outpatient diagnostic tests and therapeutic services and supplies *(continued)*	$0 copay for each Medicare-covered lab service. $0 copay for Medicare-covered and non-Medicare covered blood services. $325 copay for each Medicare-covered CT scan. $325 copay for each Medicare-covered diagnostic radiology service other than CT scans. $40 copay for each Medicare-covered diagnostic procedure and test. $0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing. An additional cost share may apply if you receive services from multiple providers.	
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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and	$400 copay for outpatient hospital observation services.	40% coinsurance for outpatient hospital observation services.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Outpatient hospital observation *(continued)* 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're 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 aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits* This fact sheet is available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. **Prior authorization may be required and is the responsibility of your provider.**		
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't 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 you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.	$350 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. $400 copay for outpatient hospital observation services. $40 copay for each Medicare-covered diagnostic procedure and test. $0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing. $0 copay for each Medicare-covered lab service. $325 copay for each Medicare-covered CT	40% coinsurance for each Medicare-covered outpatient surgery at an outpatient hospital facility. 40% coinsurance for outpatient hospital observation services. 40% coinsurance for each Medicare-covered diagnostic procedure and test. 40% coinsurance for each Medicare-covered lab service. 40% coinsurance for each Medicare-covered CT scan and Medicare-covered diagnostic radiology services other than CT scans. 40% coinsurance for each Medicare-covered x-ray.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Outpatient hospital services *(continued)* **Prior authorization may be required and is the responsibility of your provider.**	scan. $325 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 - $50 copay for each Medicare-covered x-ray. • $0 copay for services provided by your primary care provider in their office. • $50 copay for services performed by a provider other than your primary care provider. 20% coinsurance for each Medicare-covered therapeutic radiology service. $50 copay for each Medicare-covered individual session for outpatient psychiatrist service. $50 copay for each Medicare-covered group session for outpatient psychiatrist service. $50 copay for each Medicare-covered individual session for outpatient mental health service. $50 copay for each Medicare-covered group session for outpatient mental health service. $70 copay for each	40% coinsurance for each Medicare-covered therapeutic radiology service. 40% coinsurance for each Medicare-covered individual session for outpatient psychiatrist service. 40% coinsurance for each Medicare-covered group session for outpatient psychiatrist service. 40% coinsurance for each Medicare-covered individual session for outpatient mental health service. 40% coinsurance for each Medicare-covered group session for outpatient mental health service. 40% coinsurance for each Medicare-covered partial hospitalization day. 40% coinsurance for each Medicare-covered intensive outpatient visit. 40% coinsurance for Medicare-covered medical supplies. $35 copay for insulin. Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin and plan level deductibles do not apply.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Outpatient hospital services *(continued)*	Medicare-covered partial hospitalization day. $145 copay for each Medicare-covered intensive outpatient visit. 0% - 20% coinsurance for Medicare-covered medical supplies. • 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies. $35 copay for insulin. Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin and plan level deductibles do not apply. 0% - 20% coinsurance for chemotherapy drugs. • Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. 0% - 20% coinsurance for all other drugs covered under Medicare Part B. • Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. $65 copay for all other outpatient hospital services.	40% coinsurance for chemotherapy drugs. 40% coinsurance for all other drugs covered under Medicare Part B.

Covered Service	What you pay in-network	What you pay out-of-network
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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. **Prior authorization may be required and is the responsibility of your provider.**	$50 copay for each Medicare-covered individual session for outpatient psychiatrist service. $50 copay for each Medicare-covered group session for outpatient psychiatrist service. $50 copay for each Medicare-covered individual session for outpatient mental health service. $50 copay for each Medicare-covered group session for outpatient mental health service.	40% coinsurance for each Medicare-covered individual session for outpatient psychiatrist service. 40% coinsurance for each Medicare-covered group session for outpatient psychiatrist service. 40% coinsurance for each Medicare-covered individual session for outpatient mental health service. 40% coinsurance for each Medicare-covered group session for outpatient mental health service.
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).	$50 copay for each Medicare-covered occupational therapy service. $50 copay for each Medicare-covered physical and speech therapy service.	40% coinsurance for each Medicare-covered occupational therapy service. 40% coinsurance for each Medicare-covered physical and speech therapy service.
Outpatient substance use disorder 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 substance use disorder 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:	$50 copay for each Medicare-covered individual session for outpatient substance use disorder service. $50 copay for each Medicare-covered group session for outpatient substance use disorder service.	40% coinsurance for each Medicare-covered individual session for outpatient substance use disorder service. 40% coinsurance for each Medicare-covered group session for outpatient substance use disorder service.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Outpatient substance use disorder services *(continued)* • 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.**		
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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.**	$350 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. $300 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center.	40% coinsurance for each Medicare-covered outpatient surgery at an outpatient hospital facility. 40% coinsurance for each Medicare-covered outpatient surgery at an ambulatory surgical center.
Partial hospitalization services and Intensive outpatient 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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$70 copay for each Medicare-covered partial hospitalization day. $145 copay for each Medicare-covered intensive outpatient visit.	40% coinsurance for each Medicare-covered partial hospitalization day. 40% coinsurance for each Medicare-covered intensive outpatient visit.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Partial hospitalization services and Intensive outpatient services *(continued)* **Prior authorization may be required and is the responsibility of your provider.**		
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get 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 PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, as long as your provider can offer these services via telehealth, including: ◦ Primary care provider services ◦ Physician specialist services ◦ Diabetes self-management training services ◦ Kidney disease education services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Occupational therapy services ◦ Opioid treatment services ◦ Outpatient substance use disorder services (individual sessions) ◦ Outpatient substance use disorder services (group sessions) ◦ Physical and speech therapy services ◦ 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**	$0 copay for Medicare-covered primary care provider (PCP) services (including nationally contracted walk-in clinic services and urgently needed services). For a list of nationally contracted walk-in clinics, please consult your *Provider Directory*. $65 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). $65 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including: • $0 copay for each primary care provider service • $0 - $65 copay for each physician specialist service ◦ $0 copay for services in a nursing home. ◦ $65 copay for services outside a nursing home.	40% coinsurance for Medicare-covered primary care provider (PCP) services (including telehealth services and urgently needed services). 40% coinsurance for Medicare-covered physician specialist services (including surgery second opinion, telehealth services, home infusion professional services, and urgently needed services). 40% coinsurance for each Medicare-covered hearing exam.
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Physician/Practitioner services, including doctor's office visits *(continued)* ◦ 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. Not all providers offer telehealth services. ◦ You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, you 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. You can access Teladoc at **Teladoc.com/Aetna** or by calling 1-855-TELADOC (**1-855-835-2362**) (**TTY: 711**). You can find out if MinuteClinic® Video Visits are available in your area at **CVS.com/MinuteClinic/virtual-care/videovisit**. • Some telehealth services including consultation, diagnosis, and treatment by a physician or 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 • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit	• $0 copay for each diabetes self-management training service • 20% coinsurance for each kidney disease education service • $50 copay for each individual session for mental health service • $50 copay for each group session for mental health service • $50 copay for each occupational therapy service • $50 copay for each opioid treatment program service • $50 copay for each individual session for outpatient substance use disorder service • $50 copay for each group session for outpatient substance use disorder service • $50 copay for each physical therapy and speech therapy service • $50 copay for each individual session for psychiatric service • $50 copay for each group session for psychiatric service • $50 copay for each urgently needed service $0 for physician specialist services received in a nursing home.	
This benefit is continued on the next page.		

Covered Service	What you pay in-network	What you pay out-of-network
Physician/Practitioner services, including doctor's office visits *(continued)* ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • 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 phone, internet, or electronic health record • Second opinion by another network provider prior to surgery **Prior authorization may be required and is the responsibility of your provider.**		
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	$65 copay for each Medicare-covered podiatry visit.	40% coinsurance for each Medicare-covered podiatry visit.

Covered Service	What you pay in-network	What you pay out-of-network
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for each Medicare-covered PrEP service.	40% coinsurance for each Medicare-covered PrEP service.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	$0 copay for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.	$0 copay for each Medicare-covered digital rectal exam. 40% coinsurance for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. **Prior authorization may be required and is the responsibility of your provider.**	20% coinsurance for each Medicare-covered prosthetic and orthotic device. 0% - 20% coinsurance for Medicare-covered medical supplies. • 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies.	40% coinsurance for each Medicare-covered prosthetic and orthotic device. 40% coinsurance for Medicare-covered medical supplies.

Covered Service	What you pay in-network	What you pay out-of-network
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.	$15 copay for each Medicare-covered pulmonary rehabilitation service.	40% coinsurance for each Medicare-covered pulmonary rehabilitation service.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (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.	40% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.	40% coinsurance for the Medicare-covered Hepatitis C screening.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	40% coinsurance for the Medicare-covered counseling and shared decision-making visit and for the LDCT.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Screening for lung cancer with low dose computed tomography (LDCT) *(continued)* furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the members must get an 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.		
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 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.	40% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime	20% coinsurance for each Medicare-covered kidney disease education session. 20% coinsurance for Medicare-covered outpatient dialysis, self-dialysis training, certain home support services, and home dialysis equipment and supplies.	40% coinsurance for each Medicare-covered kidney disease education session. 50% coinsurance for outpatient dialysis, self-dialysis training, certain home support services, and home dialysis equipment and supplies. 40% per stay for each medically necessary

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Services to treat kidney disease *(continued)* • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're 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 Medicare Part B. For information about coverage for Part B Drugs, please go to **Medicare Part B drugs** in this table. **Prior authorization may be required and is the responsibility of your provider.**	$440 per day, days 1-6; $0 per day, days 7-90; $0 copay for additional days for each medically necessary covered inpatient stay. Cost sharing is charged for each medically necessary covered 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'd pay at a network hospital.	covered inpatient stay. Cost sharing is charged for each medically necessary covered 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'd pay at a network hospital.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Days covered: 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. Cost sharing is not charged on the day of discharge. Covered services include but aren't limited to: *This benefit is continued on the next page.*	$10 per day, days 1-20; $218 per day, days 21-100 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	40% 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

Covered Service	What you pay in-network	What you pay out-of-network
Skilled nursing facility (SNF) care *(continued)* • 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 our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • 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 provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for 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 or domestic partner is living at the time you leave the hospital **Prior authorization may be required and is the responsibility of your provider.** *Amounts you pay for blood do not apply to your in-network or combined maximum out-of-pocket amount.	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.	period begins. There is no limit to the number of benefit periods you can have.

Covered Service	What you pay in-network	What you pay out-of-network
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) In addition to Medicare-covered benefits, we also offer: • Additional (non-Medicare covered) 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 additional non-Medicare covered smoking and tobacco use cessation visit.	40% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits. 40% coinsurance for each additional non-Medicare covered smoking and tobacco use cessation visit.
Special Supplemental Benefits for the Chronically Ill You may be eligible for additional benefits. Please see the **Special Supplemental Benefits Chart** following the Medical Benefits Chart for information on benefits and eligibility requirements.	See the **Special Supplemental Benefits Chart** for information.	See the **Special Supplemental Benefits Chart** for information.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). 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	$25 copay for each Medicare-covered Supervised Exercise Therapy service.	40% coinsurance for each Medicare-covered Supervised Exercise Therapy service.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Supervised Exercise Therapy (SET) *(continued)* • 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.		
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. In addition to Medicare-covered benefits, we also offer: • Urgent care (worldwide) $250,000 annual maximum benefit for worldwide emergency care, emergency ambulance, and urgently needed care. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.	$50 copay for each Medicare-covered urgent care facility visit. Cost sharing is not waived if you are admitted to the hospital. (See **Physician/Practitioner services, including doctor's office visits** for information about urgently needed services provided in a physician's office.) $130 copay for each urgent care visit worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.	$50 copay for each Medicare-covered urgent care facility visit. Cost sharing is not waived if you are admitted to the hospital. (See **Physician/Practitioner services, including doctor's office visits** for information about urgently needed services provided in a physician's office.) $130 copay for each urgent care visit worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.

Covered Service	What you pay in-network	What you pay out-of-network
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 for glaucoma, we cover one glaucoma screening each year. People at high risk for 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 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. In addition to Medicare-covered benefits, we also offer: • Non-Medicare covered eye exams (refractions): one exam every year • Follow-up diabetic eye exam *Amounts you pay for non-Medicare covered routine eye exams do not apply to your in-network or combined maximum out-of-pocket amount. *Amounts you pay for follow-up diabetic eye exams do not apply to your in-network or combined maximum out-of-pocket amount.	$0 copay for each Medicare-covered eye exam. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received. $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 one non-Medicare covered routine eye exam with an EyeMed provider. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received.	40% coinsurance for each Medicare-covered eye exam. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received. $0 copay for each Medicare-covered glaucoma screening. 40% coinsurance for each follow-up diabetic eye exam. 40% coinsurance for Medicare-covered eyewear. $0 copay for one non-Medicare covered routine eye exam up to $50. You will be responsible for any billed amount over $50. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received.
Vision care — eyewear (non-Medicare covered) With this plan you get an annual benefit amount (allowance) of $125 every year for prescription eyewear including: • Contact lenses	Covered prescription eyewear: • Contact lenses: $0 copay • Eyeglasses (lenses and frames): $0 copay • Eyeglass lenses: $0 copay • Eyeglass frames: $0	Covered prescription eyewear: • Contact lenses: $0 copay • Eyeglasses (lenses and frames): $0 copay • Eyeglass lenses: $0 copay • Eyeglass frames: $0

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Vision care — eyewear (non-Medicare covered) *(continued)* • Eyeglasses including lenses and frames • Eyeglass lenses • Eyeglass frames • Upgrades (including UV protection and scratch coating) We have teamed up with EyeMed to provide this benefit. You can use your benefit amount (allowance) to purchase covered eyewear at an EyeMed provider. Your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll just need to pay the difference. You can choose to use a provider outside of the EyeMed network, but you may be responsible for additional costs. To find a participating EyeMed provider, you can search online at **AetnaMedicareVision.com** or call Aetna vision customer service at **1-844-486-3485** (**TTY: 711**). *Amounts you pay for additional eyewear services do not apply to your in-network or combined maximum out-of-pocket amount.	copay • Upgrades (including UV protection and scratch coating): $0 copay	copay • Upgrades (including UV protection and scratch coating): $0 copay
Welcome to Medicare preventive visit Our 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 preventive services you need (including certain screenings and shots (or vaccines)), 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 want 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.	40% coinsurance for the Welcome to Medicare preventive visit. $0 copay for a Medicare-covered EKG following the Welcome to Medicare preventive visit.
Wigs You get a $400 benefit amount (allowance) every year for covered wigs needed for hair loss due to chemotherapy. You can purchase wigs through a durable medical equipment (DME) supplier or a supplier of your choice. You are responsible for	$0 copay for a wig.	$0 copay for a wig.

This benefit is continued on the next page.

Covered Service	What you pay in-network	What you pay out-of-network
Wigs *(continued)* any costs over the benefit amount. To find a DME supplier you can call the phone number on your member ID card or visit our online directory at **aet.na/search**. If you choose to use a supplier that is not in the DME network, you will need to pay out-of-pocket and submit a claim for reimbursement along with the receipt. You will only be reimbursed up to the benefit amount. You can find the reimbursement form at **AetnaMedicare.com/forms**.		

Special Supplemental Benefits Chart

Members enrolled in this plan may qualify for additional benefits. The chart below describes the eligibility requirements and benefits that may be available.

Extra Supports Wallet

Eligibility requirements:
If you are diagnosed with one or more of the chronic conditions listed below, meet certain criteria, and you get Extra Help to help with your Medicare prescription drug program costs, you may be eligible for additional benefits under our plan. Enrollment in the plan does not guarantee eligibility. You will receive Special Supplemental Benefits after it is determined that you meet the eligibility requirements. However, you will not receive benefits for any time period before your eligibility was determined.

- Anemia
- Autoimmune disorders limited to:
  - Dermatomyositis
  - Polyarteritis nodosa
  - Polymyalgia rheumatica
  - Polymyositis
  - Psoriatic arthritis
  - Rheumatoid arthritis
  - Scleroderma
  - Systemic lupus erythematosus
- Cancer
- Cardiovascular disorders limited to:
  - Cardiac arrhythmias
  - Coronary artery disease
  - Peripheral vascular disease
  - Valvular heart disease
- Chronic alcohol use disorder and other substance use disorders (SUDS)
- Chronic and disabling mental health conditions limited to:
  - Anxiety disorders
  - Bipolar disorders
  - Eating disorders
  - Major depressive disorders
  - Paranoid disorder
  - Post-traumatic stress disorder (PTSD)
  - Schizophrenia
  - Schizoaffective disorder
- Chronic conditions that impair vision, hearing (deafness), taste, touch and smell
- Chronic gastrointestinal disease limited to:
  - Chronic liver disease
  - Hepatitis B
  - Hepatitis C
  - Irritable bowel syndrome
  - Inflammatory bowel disease
  - Non-alcoholic fatty liver disease (NAFLD)

Special Supplemental Benefits Chart

Eligibility requirements (continued)

    - Pancreatitis
- Chronic heart failure
- Chronic hyperlipidemia
- Chronic hypertension
- Chronic kidney disease (CKD) limited to:
    - CKD not requiring dialysis
    - CKD requiring dialysis/End-stage renal disease (ESRD)
- Chronic lung disorders limited to:
    - Asthma
    - Chronic bronchitis
    - Chronic obstructive pulmonary disease (COPD)
    - Cystic fibrosis
    - Emphysema
    - Pulmonary fibrosis
    - Pulmonary hypertension
- Chronic pain
- Conditions associated with cognitive impairment limited to:
    - Alzheimer's disease
    - Disabling mental illness associated with cognitive impairment
    - Intellectual disabilities and developmental disabilities
    - Mild cognitive impairment
    - Traumatic brain injuries
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges and require similar services including the following:
    - Arthritis
    - Limb loss
    - Paralysis
    - Spinal cord injuries
    - Stroke
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Immunodeficiency and immunosuppressive disorders
- Neurologic disorders limited to:
    - Amyotrophic lateral sclerosis (ALS)
    - Chronic fatigue syndrome
    - Epilepsy
    - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
    - Fibromyalgia
    - Huntington's disease
    - Multiple sclerosis (MS)
    - Parkinson's disease

Special Supplemental Benefits Chart

- Polyneuropathy
- Spinal cord injuries
- Spinal stenosis
- Stroke-related neurologic deficit

- Overweight, obesity, and metabolic syndrome
- Post-organ transplantation care
- Severe hematologic disorders limited to:
  - Aplastic anemia
  - Chronic venous thromboembolic disorder
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
- Stroke

Self-attestation is only available for new Aetna members by following the process below. Returning member eligibility will be determined through medical claims review. This means you may not be determined eligible for this benefit until after your plan start date. Returning members cannot self-attest to a diagnosis for the chronic conditions listed. However, returning members can submit a provider attestation that confirms they have been diagnosed with one of the above conditions. If you have questions about provider attestations, call the Member Services number on your member ID card.

Instructions for self-attestation
As a new member, you can self-attest to determine if you qualify for Special Supplemental Benefits by calling Member Services at the number on your member ID card.

If you have questions about this benefit or your eligibility, call the Member Services number on your member ID card.

Benefits	What you must pay when you get these services

If you qualify, you get an **Extra Supports Wallet** with a $15 quarterly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card to pay for:
• Healthy foods including meat, produce, dairy products, and more.
  ◦ Approved healthy food can be purchased in-store at participating retail stores and online at **CVS.com/Aetna** or by phone at **1-844-428-8147** (**TTY: 711**).
  ◦ Examples of products that are not eligible include tobacco, alcohol, candy, soda, and non-food products.
• Over-the-counter (OTC) approved health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. This benefit includes certain nicotine replacement therapies.
	There is no coinsurance, copayment, or deductible for the Extra Supports Wallet.
	
	The Extra Benefits Card can only be used at participating retail locations and online or by phone through CVS.

This benefit is continued on the next page.	

Benefits	What you must pay when you get these services
Extra Supports Wallet *(continued)* ◦ Approved OTC products can be purchased in-store at participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at **CVS.com/Aetna** or by phone at **1-844-428-8147** (**TTY:** **711**). • Transportation including gas at the pump, public transportation, and certain ride share services. ◦ Gas must be purchased at the pump by swiping the card and selecting credit as the payment type. ◦ The card cannot be used to purchase gas or products inside of a store at the gas station. ◦ Gas purchases are subject to holds and funds may be unavailable while that transaction is being processed. ◦ For ride share services, you will need to download the corresponding app and add the Aetna Medicare Extra Benefits Card as your payment type. • Utilities including gas, electric, water, sewer, landline, cell phone, and internet service. ◦ The utility provider must accept Visa®. Utility expenses must be paid directly to the utility provider using the card. • Personal care products including paper towels, shampoo, soap, and more. ◦ Approved personal care products can be purchased in-store at participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at **CVS.com/Aetna** or by phone at **1-844-428-8147** (**TTY:** **711**). Your eligibility for this wallet must be determined by the 15th day of the last month of the quarter, in order to receive the benefit amount for that quarter. If eligibility is determined after the 15th day of the last month of that quarter, the benefit amount will be available the following quarter. Going forward, for each quarter you are eligible, the benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each calendar quarter. Calendar quarters begin in January, April, July, and October. Be sure to use the full benefit amount each quarter, because any unused benefit amount will not roll over into the next quarter nor will it roll over into the next plan year. There are no exceptions to request additional or unused funds to be added to your card. **Important:** Aetna is not responsible for fees associated with late utility payments. All products and services are subject to tax (depending on your state). Your card balance will be used to cover taxes. If there are not enough funds on your card to cover the taxes, they will be your responsibility to cover. For more information on the Aetna Medicare Extra Benefits Card, see the Aetna Medicare Extra Benefits Card section in Chapter 4.	

2026 Deluxe PPO Mandatory Dental Schedule of Benefits

Our plan offers supplemental dental benefits. This Schedule of Benefits describes your covered benefits and services. You are responsible for cost shares listed in the table below when you're treated by a dentist. If you get a service not listed in the table, you will have to pay the full cost. You can take this document to verify your coverage with your dentist. To locate a participating dentist, you can call Member Services or go online at **AetnaMedicare.com/dental**.

Preventive Services				
Maximum Benefit: None				
			What you must pay when you get these services	
CDT Code	**Description**	**Frequency**	**in-network**	**out-of-network**
D0120	periodic oral evaluation - established patient	Two procedures from this code group per calendar year	$0	50%
D0150	comprehensive oral evaluation - new or established patient		$0	50%
D0140	limited oral evaluation - problem focused	Two procedures from this code group per calendar year	$0	50%
D0461	testing for cracked tooth		$0	50%
D0180	comprehensive periodontal evaluation - new or established patient		$0	50%
D1110	prophylaxis - adult	two procedures per calendar year	$0	50%
D0270	bitewing - single radiographic image	One set of x-rays from this code group per calendar year	$0	50%
D0272	bitewings - two radiographic images		$0	50%
D0273	bitewings - three radiographic images		$0	50%
D0274	bitewings - four radiographic images		$0	50%
D0373	intraoral tomosynthesis – bitewing radiographic image		$0	50%
D0220	intraoral - periapical first radiographic image	N/A	$0	50%
D0230	intraoral - periapical each additional radiographic image		$0	50%
D0374	intraoral tomosynthesis – periapical radiographic image		$0	50%
D0210	intraoral – comprehensive series of radiographic images	One procedure from this code group every three years	$0	50%
D0330	panoramic radiographic image		$0	50%
D0372	intraoral tomosynthesis – comprehensive series of radiographic images		$0	50%

Comprehensive Services				
Maximum Benefit: $1,000				
			What you must pay when you get these services	
CDT Code	**Description**	**Frequency**	**in-network**	**out-of-network**
D2140	amalgam - one surface, primary or permanent	Two procedures from this code group per tooth per calendar year	20%	50%
D2150	amalgam - two surfaces, primary or permanent		20%	50%
D2160	amalgam - three surfaces, primary or permanent		20%	50%
D2161	amalgam - four or more surfaces, primary or permanent		20%	50%
D2330	resin-based composite - one surface, anterior		20%	50%
D2331	resin-based composite - two surfaces, anterior		20%	50%
D2332	resin-based composite - three surfaces, anterior		20%	50%
D2335	resin-based composite - four or more surfaces (anterior)		20%	50%
D2390	resin-based composite crown, anterior		20%	50%
D2391	resin-based composite - one surface, posterior		20%	50%
D2392	resin-based composite - two surfaces, posterior		20%	50%
D2393	resin-based composite - three surfaces, posterior		20%	50%
D2394	resin-based composite - four or more surfaces, posterior		20%	50%
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	One procedure from this code group per tooth per calendar year	20%	50%
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		20%	50%
D2920	re-cement or re-bond crown		20%	50%
D3310	endodontic therapy, anterior tooth (excluding final restoration)	One procedure from this code group per tooth per lifetime	20%	50%
D3320	endodontic therapy, premolar tooth (excluding final restoration)		20%	50%
D3330	endodontic therapy, molar tooth (excluding final restoration)		20%	50%
D3346	retreatment of previous root canal therapy - anterior	One procedure from this group per tooth per lifetime	20%	50%
D3347	retreatment of previous root canal therapy - premolar		20%	50%

CDT Code	Description	Frequency	in-network	out-of-network
D3348	retreatment of previous root canal therapy - molar		20%	50%
D4341	periodontal scaling and root planing - four or more teeth per quadrant	One procedure from this code group per quad every two years	20%	50%
D4342	periodontal scaling and root planing - one to three teeth per quadrant		20%	50%
D4910	periodontal maintenance	two per calendar year	20%	50%
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	one extraction per tooth per lifetime	20%	50%
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		20%	50%
D7220	removal of impacted tooth - soft tissue		20%	50%
D7250	removal of residual tooth roots (cutting procedure)		20%	50%
D9110	palliative treatment of dental pain – per visit	N/A	20%	50%
D2950	core buildup, including any pins when required	One procedure from this code group per tooth every 5 years	50%	70%
D2952	post and core in addition to crown, indirectly fabricated		50%	70%
D2953	each additional indirectly fabricated post - same tooth		50%	70%
D2954	prefabricated post and core in addition to crown		50%	70%
D2957	each additional prefabricated post - same tooth		50%	70%
D2740	crown - porcelain/ceramic	One procedure from this code group per tooth every 5 years	50%	70%
D2750	crown - porcelain fused to high noble metal		50%	70%
D2751	crown - porcelain fused to predominantly base metal		50%	70%
D2752	crown - porcelain fused to noble metal		50%	70%
D2753	crown - porcelain fused to titanium and titanium alloys		50%	70%
D2780	crown - 3/4 cast high noble metal		50%	70%
D2781	crown - 3/4 cast predominantly base metal		50%	70%
D2782	crown - 3/4 cast noble metal		50%	70%
D2783	crown - 3/4 porcelain/ceramic		50%	70%
D2790	crown - full cast high noble metal		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D2791	crown - full cast predominantly base metal		50%	70%
D2792	crown - full cast noble metal		50%	70%
D2980	crown repair necessitated by restorative material failure	one per tooth per calendar year	50%	70%
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	one per lifetime	50%	70%
D5110	complete denture - maxillary	One procedure from this code group, including D5877 and D5878, per arch every 5 years	50%	70%
D5120	complete denture - mandibular		50%	70%
D5130	immediate denture - maxillary		50%	70%
D5140	immediate denture - mandibular		50%	70%
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	One procedure from this code group, per arch every 5 years	50%	70%
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)		50%	70%
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	70%
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	70%
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)		50%	70%
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)		50%	70%
D5282	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary		50%	70%
D5283	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular		50%	70%
D5284	removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D5286	removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant		50%	70%
D5410	adjust complete denture - maxillary	as needed	50%	70%
D5411	adjust complete denture - mandibular		50%	70%
D5421	adjust partial denture - maxillary		50%	70%
D5422	adjust partial denture - mandibular		50%	70%
D5511	repair broken complete denture base, mandibular		50%	70%
D5512	repair broken complete denture base, maxillary		50%	70%
D5520	replace missing or broken teeth – complete denture – per tooth		50%	70%
D5611	repair resin partial denture base, mandibular		50%	70%
D5612	repair resin partial denture base, maxillary		50%	70%
D5621	repair cast partial framework, mandibular		50%	70%
D5622	repair cast partial framework, maxillary		50%	70%
D5630	repair or replace broken retentive clasping materials – per tooth		50%	70%
D5640	replace missing or broken teeth – partial denture – per tooth		50%	70%
D5650	add tooth to existing partial denture – per tooth		50%	70%
D5660	add clasp to existing partial denture - per tooth		50%	70%
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		50%	70%
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		50%	70%
D5710	rebase complete maxillary denture		50%	70%
D5711	rebase complete mandibular denture		50%	70%
D5720	rebase maxillary partial denture		50%	70%
D5721	rebase mandibular partial denture		50%	70%
D5730	reline complete maxillary denture (direct)		50%	70%
D5731	reline complete mandibular denture (direct)		50%	70%
D5740	reline maxillary partial denture (direct)		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D5741	reline mandibular partial denture (direct)		50%	70%
D5750	reline complete maxillary denture (indirect)		50%	70%
D5751	reline complete mandibular denture (indirect)		50%	70%
D5760	reline maxillary partial denture (indirect)		50%	70%
D5761	reline mandibular partial denture (indirect)		50%	70%
D5876	add metal substructure to acrylic complete denture - per arch		50%	70%
D5877	duplication of complete denture - maxillary	One procedure from this code group including D5110, D5120, D5130, and D5140, per arch every 5 years	50%	70%
D5878	duplication of complete denture - mandibular		50%	70%
D6980	fixed partial denture repair necessitated by restorative material failure	N/A	50%	70%
D6210	pontic - cast high noble metal	One procedure from this code group per tooth every 5 years	50%	70%
D6211	pontic - cast predominantly base metal		50%	70%
D6212	pontic - cast noble metal		50%	70%
D6240	pontic - porcelain fused to high noble metal		50%	70%
D6241	pontic - porcelain fused to predominantly base metal		50%	70%
D6242	pontic - porcelain fused to noble metal		50%	70%
D6243	pontic - porcelain fused to titanium and titanium alloys		50%	70%
D6245	pontic - porcelain/ceramic		50%	70%
D6250	pontic - resin with high noble metal		50%	70%
D6251	pontic - resin with predominantly base metal		50%	70%
D6252	pontic - resin with noble metal		50%	70%
D6545	retainer - cast metal for resin bonded fixed prosthesis	One procedure from this code group per tooth every 5 years	50%	70%
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis		50%	70%
D6720	retainer crown - resin with high noble metal		50%	70%
D6721	retainer crown - resin with predominantly base metal		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D6722	retainer crown - resin with noble metal		50%	70%
D6740	retainer crown - porcelain/ceramic		50%	70%
D6750	retainer crown - porcelain fused to high noble metal		50%	70%
D6751	retainer crown - porcelain fused to predominantly base metal		50%	70%
D6752	retainer crown - porcelain fused to noble metal		50%	70%
D6753	retainer crown - porcelain fused to titanium and titanium alloys		50%	70%
D6780	retainer crown - 3/4 cast high noble metal		50%	70%
D6781	retainer crown - 3/4 cast predominantly base metal		50%	70%
D6782	retainer crown - 3/4 cast noble metal		50%	70%
D6783	retainer crown - 3/4 porcelain/ceramic		50%	70%
D6784	retainer crown ¾ - titanium and titanium alloys		50%	70%
D6790	retainer crown - full cast high noble metal		50%	70%
D6791	retainer crown - full cast predominantly base metal		50%	70%
D6792	retainer crown - full cast noble metal		50%	70%
D7230	removal of impacted tooth - partially bony	once extraction per tooth per lifetime	50%	70%
D7240	removal of impacted tooth - completely bony		50%	70%
D7241	removal of impacted tooth - completely bony, with unusual surgical complications		50%	70%
D9128	photobiomodulation therapy - first 15 minute increment, or any portion thereof	N/A	50%	70%
D9129	photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof	N/A	50%	70%
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	N/A	50%	70%
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof		50%	70%
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof		50%	70%
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof		50%	70%
D9239	administration of moderate sedation – intravenous - first 15 minute increment, or any portion thereof		50%	70%
D9243	administration of moderate sedation – intravenous - each subsequent 15 minute increment, or any portion thereof		50%	70%
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof		50%	70%
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof		50%	70%
D9613	infiltration of sustained release therapeutic drug, per quadrant		50%	70%

Out-of-pocket costs
You will be responsible for payment of services and charges billed by a provider that exceed coverage limitations. You may also be required to pay your cost share at the time of service. Billing arrangements are between you and the provider. In addition, if you obtain services from a dental provider that is not part of our network, you may be required to pay up to the cost of the service at the time services are provided. And then submit for reimbursement. The reimbursement request will be reviewed and a decision will be made based upon the information provided. Reimbursement is not guaranteed. You can submit a Medical Member Reimbursement Form to Aetna Medicare, PO Box 981106, El Paso, TX 79998-1106. You can get this form by calling Member Services or you can fill out and submit the form online at **AetnaMedicare.com/forms**. In addition, if you obtain services from a dental provider that is not part of our network, you will be responsible for payment of the full cost of the services.

Limitations & Exclusions

1. Coverage is limited to the services and service frequencies listed in the Schedule of Benefits. If a service is not listed, it is not covered.
2. Any dental services received outside of the U.S. or U.S. territories are not covered under the supplemental dental benefit.
3. Fees related to missed appointments, preparing or copying dental reports, duplication of x rays, itemized bills or claim forms are not covered.

4. 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.
5. 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.
6. 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.
7. Orthodontic and all orthodontic related services are not covered
8. Implants and all implant related services are not covered
9. Maxillofacial prosthetics are not covered
10. Dental services performed for cosmetic and/or aesthetic reasons are not covered
11. Tooth bleaching and/or enamel microabrasion services are not covered
12. Unspecified services by report (Dental codes: D##99) are not covered
13. Dental services related to temporomandibular joint syndrome (TMJ) are not covered, unless the related dental code is listed in the schedule of benefits
14. Elective services are not covered
15. General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periarticular surgical procedures for covered services.
16. Altering vertical dimension of teeth, or restoration/maintenance of occlusion including bite registration or bite analysis are not covered.
17. Splinting teeth, including multiple abutments, or any services to stabilize periodontally weakened teeth are not covered.
18. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction are not covered.
19. Plan frequency limitations will still apply when there is a replacement of a device or appliance that is lost, missing, stolen, or damaged due to abuse, misuse or neglect.
20. Dental procedures are only covered when performed by a dentist licensed in the US or any US territory.
21. Periodontal maintenance is not covered unless there is a history of scaling and root planing or surgical periodontal therapy.
22. Denture adjustments performed within 6 months of denture placement/installation, reline, or rebase are not covered.
23. Denture reline and rebase, if listed as covered in your schedule of benefits, performed within 6 months following the placement of a complete or immediate denture are not covered.
24. Tissue conditioning performed within 6 months of denture placement, reline, or rebase are not covered.
25. For covered dental procedures listed in your schedule of benefits, the treatment date for billing purposes is defined by completion of specific procedures.
    For removable dentures (complete and partial), this is the delivery date. For inlays, onlays, crowns, veneers and bridges, it's the date of final cementation. For root canals, it's the date the final fill is placed.
26. Procedures that are considered experimental, investigational or unproven are not covered. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics.
27. If this policy is terminated or the covered dental services for this plan change, this plan will not cover ongoing care or treatment. This includes all multi-appointment procedures.
28. Services and supplies provided in connection with treatment or care that is not covered under the plan are not covered.

Medical Necessity
Your plan covers clinically appropriate dental care services. This is a requirement for you to receive a covered benefit under this plan. Dental care services that we determine a provider using prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that we determine are:

1. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
2. Not primarily for the convenience of the patient, dentist, or other health care provider
3. Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

Medical necessity is determined using criteria that are:

- *Consistent with generally accepted standards of medical and dental practice*
- *Based on evidence from peer-reviewed literature and clinical guidelines*
- *Applied uniformly and without regard to cost considerations*

Alternate Benefits
The alternate benefit provision applies when more than one dental service is suitable to treat a dental condition. In these cases, Aetna will cover the lower-cost treatment option (alternate benefit). That means you are responsible for any coinsurance amounts applicable to the alternate benefit, **plus** any difference in cost between the alternate benefit and the actual service received. To ensure you understand your treatment options and costs, you can work with your dental provider to submit an advance claim review.

An advance claim review
The purpose of an advance claim review is to provide an estimate, of what we may pay for proposed services. Knowing ahead of time which services are eligible dental services and what your plan may pay helps you and your dentist make informed decisions about the care you are considering. The estimate is not a guarantee of coverage and payment. In estimating the amount of benefits payable, we will look at alternate procedures, services, or courses of treatment for the dental condition in question in order to meet the expected result. The estimate is voluntary.

When to get an advance claim review
To understand your cost share for a course of dental treatment you can request an advance claim review. Here are the steps for getting an advance claim review:

1. Ask your dentist to write down a full description of the treatment you need. They must either use an Aetna claim form or an American Dental Association (ADA) approved claim form.
2. Your dentist should send the form to us before treating you.
3. We may request supporting images and other diagnostic records.
4. Once all of the information has been gathered, we will review the proposed treatment plan and provide you and your dentist with a statement outlining the estimated benefits payable and your out-of-pocket costs.
5. You and your dentist can then decide how to proceed.

What is a course of dental treatment? A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

Section 2.1 Get care using our plan's optional visitor/traveler benefit

When you are continuously absent from our plan's service area for more than 6 months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit a visitor/traveler program that is available within the United States that will allow you to stay enrolled in our plan when you're in the visitor/traveler area and outside of our plan's service area for up to 12 months. This program is available to all Aetna Medicare Value Plus (PPO) members who are temporarily in the visitor/traveler area and outside our plan's service area. Under our visitor/traveler program you can get all plan-covered services at in-network cost sharing when you see a network provider. In most cases, when you receive non-urgent/non-emergency care from an out-of-network provider (a provider who is not an Aetna Medicare provider), your share of the costs for your covered services may be higher (See Chapter 3, Section 2.3 for more information). Contact our plan for help in locating a provider when using the visitor/traveler benefit.

If you're in the visitor/traveler area and outside the plan's service area, you can stay enrolled in our plan for up to 12 months. If you don't return to our plan's service area within 12 months, you'll be disenrolled from the plan. Please be sure to notify us when you will be out of our plan's service area for more than 6 months.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself, except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered and our plan won't pay for them. The only exception is if the service is appealed and decided 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 made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	• Available for people with chronic low back pain under certain circumstances.
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	Covered only under specific conditions
Custodial care Custodial care is personal care that doesn't 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.	Not covered under any condition.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by 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. • (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition.
Full-time nursing care in your home.	Not covered under any condition.
Home-delivered meals	Not covered under any condition.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition.
Naturopath services (uses natural or alternative treatments).	Not covered under any condition.
Non-routine dental care	• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
Private room in a hospital	• Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition.
Routine chiropractic care	• Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	• Our plan provides some coverage for dental services as described in the Medical Benefits Chart.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	• One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. • Routine eye exams: Our plan provides some coverage for routine eye exams as described in the Medical Benefits Chart. • Eyewear: Our plan provides some additional coverage for eyewear as described in the Medical Benefits Chart.
Routine foot care	• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
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 Original Medicare standards	Not covered under any condition.

CHAPTER 5:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2.) Or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (Go to Section 3.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area
To find a network pharmacy, go to your *Provider & Pharmacy Directory*, visit our website (**AetnaMedicare.com/findpharmacy**), and/or call Member Services at **1-833-570-6670** (TTY users call **711**).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider & Pharmacy Directory* will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network
If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, call Member Services at **1-833-570-6670** (TTY users call **711**) or use the *Provider & Pharmacy Directory*. You can also find information on our website at **AetnaMedicare.com/findpharmacy**.

Specialized pharmacies
Some 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 LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at **1-833-570-6670** (TTY users call **711**).
- 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 restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Provider & Pharmacy Directory* (**AetnaMedicare.com/findpharmacy**) or call Member Services at **1-833-570-6670** (TTY users call **711**).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail-order are drugs you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as "**MO"** 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, please visit our website (**AetnaMedicare.com/MailOrder**) or contact Member Services. Note: you must have a method of payment on file.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. If the mail-order pharmacy expects the order to be delayed, they will notify you of the delay. If you need to request a rush order because of a mail-order delay, you may contact Member Services to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second-day or next-day delivery of your medications, you may request this from the Member Services representative for an additional charge.

New prescriptions the pharmacy gets directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it gets 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 can ask for automatic delivery of all new prescriptions now or at any time by continuing to have your doctor send us your prescriptions. No special request is needed. Or you may contact Member Services to restart automatic deliveries if you previously stopped automatic deliveries.

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Member Services.

If you 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. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's

office, contact us by calling Member Services.

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 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 before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy *15* days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling Member Services.

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 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 you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider & Pharmacy Directory* (**AetnaMedicare.com/findpharmacy**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at **1-833-570-6670** (TTY users call **711**) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at 1-833-570-6670 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out-of-stock at an accessible network retail or mail-order pharmacy (including high-cost and unique drugs).
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

Even if we do cover the drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to an in-network pharmacy.

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.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your

normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that's sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List
Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7).
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that isn't on our Drug List. (For more information, go to Chapter 9.)

Section 3.2 5 cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- **Tier 1: Preferred Generic**
  Many common lower cost generic drugs.
- **Tier 2: Generic**
  Higher cost generic drugs.
- **Tier 3: Preferred Brand**
  Many common brand name drugs and some higher cost generic drugs.
- **Tier 4: Non-Preferred Drug**
  Higher cost brand name and generic drugs for which a lower cost alternative is often available.
- **Tier 5: Specialty**
  High-cost brand and generic drugs meeting Medicare's definition of a specialty drug.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (**AetnaMedicare.com/formulary**). The Drug List on the website is always the most current.
- Call Member Services at **1-833-570-6670** (TTY users call **711**) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (**AetnaMedicare.com**) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at **1-833-570-6670** (TTY users call **711**).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at **1-833-570-6670** (TTY users call **711**) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you 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. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization.** This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at **1-833-570-6670** (TTY users call **711**) or on our website at **AetnaMedicare.com/formulary**.

Trying a different drug first
This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.** Our plan's step therapy criteria can be obtained by calling Member Services at **1-833-570-6670** (TTY users call **711**) or on our website at **AetnaMedicare.com/formulary**.

Quantity limits
For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's 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 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, that isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.
If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover our drug or remove restrictions from the drug.

You may be able to get a temporary supply
Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way.**

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for

fewer days, we'll 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. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:**
  We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- 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 temporary supply of the drug. This temporary supply (up to 31 days) will allow you time to talk with your doctor about the change in coverage.

For questions about a temporary supply, call Member Services at **1-833-570-6670** (TTY users call **711**).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug
Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at **1-833-570-6670** (TTY users call **711**) 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.

Option 2. You can ask for an exception
You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it's not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we'll authorize coverage for the drug before the change takes effect.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug
If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at **1-833-570-6670** (TTY users call **711**) 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.

You can ask for an exception
You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs on our Specialty (Tier 5) aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

Information on changes to drug coverage
When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this

happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.

- **Making 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 example, based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year
We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale.

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in **Appendix A** at the back of this document.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't 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** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Provider & Pharmacy Directory* (**AetnaMedicare.com/findpharmacy**) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or assistance, call Member Services at **1-833-570-6670** (TTY users call **711**). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that isn't on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:
Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in a Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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 like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same 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 for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

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

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

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers 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'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and 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'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at **1-833-570-6670** (TTY users call **711**).

CHAPTER 6:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **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, call Member Services at **1-833-570-6670** (TTY users call **711**) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage **AetnaMedicare.com**, the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at **1-833-570-6670** (TTY users call **711**).

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

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities

Moving to the Catastrophic Coverage Stage:
When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the

calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Your monthly plan premium.
- Drugs you buy outside the United States and its territories.
- Drugs that aren't covered by our plan.
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward drugs not normally covered in a Medicare Drug Plan.
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation.)
- Payments made by drug manufacturers under the Manufacturer Discount Program.

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at **1-833-570-6670** (TTY users call **711**).

Tracking your out-of-pocket total

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for Aetna Medicare Value Plus (PPO) members

There are **3 drug payment stages** for your drug coverage under Aetna Medicare Value Plus (PPO). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

Stage 1: Yearly Deductible Stage
Stage 2: Initial Coverage Stage
Stage 3: Catastrophic Coverage Stage

SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions**. This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 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's how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we won't 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, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you**. Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. 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 get the *Part D EOB,* look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at **1-833-570-6670** (TTY users call **711**). Be sure to keep these reports.

SECTION 4 The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.

You'll pay a yearly deductible of $615 on your Tier 3, Tier 4, and Tier 5 drugs. **You must pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs** until you reach our plan's deductible amount. For all other drugs you won't have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay $615 for your Tier 3, Tier 4, and Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment *or* coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has 5 cost-sharing tiers
Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Tier 1: Preferred Generic**
  Many common lower cost generic drugs.
- **Tier 2: Generic**
  Higher cost generic drugs.
- **Tier 3: Preferred Brand**
  Many common brand name drugs and some higher cost generic drugs.
- **Tier 4: Non-Preferred Drug**
  Higher cost brand name and generic drugs for which a lower cost alternative is often available.
- **Tier 5: Specialty**
  High-cost brand and generic drugs meeting Medicare's definition of a specialty drug.
- **Insulins:** Regardless of tier, you pay no more than $35 per month supply of each covered insulin product.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices
How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers standard cost sharing.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider & Pharmacy Directory* (**AetnaMedicare.com/findpharmacy**).

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you will pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Tier	**Standard retail in-network cost sharing** (up to a 30-day supply)	**Preferred retail in-network cost sharing** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Preferred mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 10-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$2	$0	$2	$0	$2	$2
Cost-Sharing Tier 2 (Generic)	$12	$0	$12	$0	$12	$12
Cost-Sharing Tier 3 (Preferred Brand)	22%	22%	22%	22%	22%	22%
Cost-Sharing Tier 4 (Non-Preferred Drug)	25%	25%	25%	25%	25%	25%
Cost-Sharing Tier 5 (Specialty)	25%	25%	25%	25%	25%	25%
Insulins	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.					

Go to Section 7 of this chapter for more information on cost-sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply, if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your costs will be lower since the total cost for the

drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *long-term* (up to a 100-day) supply for a covered Part D drug

Tier	**Standard retail cost sharing (in-network)** (up to a 100-day supply)	**Preferred retail cost sharing (in-network)** (up to a 100-day supply)	**Mail-order cost sharing** (up to a 100-day supply)	**Preferred mail-order cost sharing** (up to a 100-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$6	$0	$6	$0
Cost-Sharing Tier 2 (Generic)	$36	$0	$36	$0
Cost-Sharing Tier 3 (Preferred Brand)	22%	22%	22%	22%
Cost-Sharing Tier 4 (Non-Preferred Drug)	25%	25%	25%	25%
Cost-Sharing Tier 5 (Specialty)	A long-term supply is not available for drugs in Tier 5.			
Insulins	You won't pay more than $70 for up to a 2-month supply or $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.			

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,100**. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties, have

spent on your behalf during the year. Not all members will reach the **$2,100** out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your Part D covered drugs.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines — Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible. Go to our plan's Drug List or call Member Services at **1-833-570-6670** (TTY users call **711**) for coverage and cost-sharing details about specific vaccines**.**

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Or, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

CHAPTER 7:
Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's 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 covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got medical care from a provider who's not in our plan's network**
   When you got care from a provider who isn't part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
   - While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

2. When a network provider sends you a bill you think you shouldn't pay
Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't 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's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan
Sometimes a person's enrollment in our plan is retroactive. (This 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 costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription
If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you
If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 the drug isn't covered for some reason.

    - For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll 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'll 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 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send 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. **You must submit your medical and Part B vaccine claims to us within 12 months** of the date you got the service, item, or Part B drug. **You must submit your Part D prescription drug and Part D vaccine claims to us within 36 months** of the date you got the service, item, or Part D drug.

To make sure you're 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'll help us process the information faster. The form requires you to provide information such as: name, address, Aetna ID number, provider name, provider NPI (national provider identifier), provider TIN (taxpayer identification number), provider address, date of service, reimbursement type, description of service(s), and charge(s).
- Download a copy of the form from our website (**AetnaMedicare.com**) or call Member Services at **1-833-570-6670** (TTY users call **711**) and ask for the form.

For medical claims (including vaccines for preventing COVID-19, Flu/influenza, Pneumonia): 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

For Part D prescription drug claims (including vaccines for preventing Shingles or Chickenpox): Mail your request for payment together with any bills or paid receipts to us at this address:

Aetna Pharmacy Management
PO Box 52446
Phoenix, AZ 85072-2446

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include but aren't limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Spanish, and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at **1-833-570-6670** (TTY users call **711**).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services (phone numbers are printed on the back cover of this document). You can also call to file a complaint with Medicare by calling 1-800-MEDICARE (**1-800-633-4227**) or directly with the Office for Civil Rights **1-800-368-1019** or TTY **1-800-537-7697**.

Sección 1.1 Debemos proporcionarle información de una manera que sea conveniente para usted y compatible con sus sensibilidades culturales (en otros idiomas además de español, en braille, en tamaño de letra grande o en otros formatos alternativos, etc.).

Nuestro plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de forma culturalmente competente y sean accesibles a todos los inscritos, incluidos los que tienen un dominio limitado del inglés, una capacidad limitada de lectura, una incapacidad auditiva o un origen cultural y étnico diverso. Entre los ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad se incluyen, entre otros, proveer servicios de traducción, servicios de interpretación, teletipos o TTY (teléfono o teléfono de teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder las preguntas de los miembros que no hablan inglés. También podemos brindarle información en otros idiomas además de inglés, incluido español y braille, en letra grande u otros formatos alternativos, sin costo alguno si lo necesita. Tenemos la obligación de brindarle información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener información nuestra de una manera que sea conveniente para usted, llame a Servicios para Miembros al **1-833-570-6670** (los usuarios de TTY

deben llamar al **711**).

Nuestro plan está obligado a brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para las mujeres.

Si no hay proveedores de una especialidad disponibles en la red de nuestro plan, es responsabilidad de nuestro plan localizar proveedores especializados fuera de la red que le proporcionen la atención necesaria. En este caso, usted solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red de nuestro plan que cubran el servicio que necesita, llame al plan para obtener información sobre dónde puede obtener este servicio al costo compartido dentro de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, para consultar a un especialista en salud de la mujer o para encontrar un especialista de la red, llame para presentar una queja ante el Servicio para Miembros al **1-833-570-6670** (los usuarios de TTY deben llamar al **711**). También puede presentar un reclamo ante Medicare llamando al 1-800-MEDICARE (**1-800-633-4227**) o directamente ante la Oficina de Derechos Civiles llamando al **1-800-368-1019** o, si es usuario de TTY, al **1-800-537-7697**.

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

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You have the right to get appointments and covered services from your 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 you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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.
- You have rights related to your 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.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we're required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These

exceptions are allowed or required by law.
- We're required to release health information to government agencies that are checking on quality of care.
- Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others
You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll 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 aren't routine. You have the right to make recommendations regarding our organizations member rights and responsibilities policy.

If you have questions or concerns about the privacy of your personal health information, call Member Services at **1-833-570-6670** (TTY users call **711**).

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

As a member of Aetna Medicare Value Plus (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at **1-833-570-6670** (TTY users call **711**):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.
- **Information from interpreters.** Our plan interpreter services are available in all languages including American Sign Language. Interpreter services are available for on-site interpretation during a medical appointment. If you require these services, please contact Member Services at least two weeks in advance of your scheduled appointment.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're 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. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at **1-833-570-6670** (TTY users call **711**) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed
If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it,

you can file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your State Health Insurance Assistance Program (SHIP). Contact information is in **Appendix A** at the back of this document.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at 1-833-570-6670 (TTY users call 711)**
- **Call your local SHIP**. Phone numbers are listed in **Appendix A** at the back of this document.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-833-570-6670 (TTY users call 711)**
- **Call your local SHIP**. Phone numbers are listed in **Appendix A** at the back of this document.
- **Contact Medicare**.
  - Visit **www.Medicare.gov** to read the publication *Medicare Rights & Protections* (available at: **www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf**.)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-833-570-6670 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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 a plan member, you're responsible for these payments:
  - You must pay our plan premiums
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at **1-833-570-6670** (TTY users call **711**) for help. In some situations, you may always want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)
Each state has a government program with trained counselors. 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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in **Appendix A** at the back of this document.

Medicare
You can also contact Medicare help.

- Call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.
- Visit **Medicare.gov**.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?
This includes problems about whether medical care (medical items, services, and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care.** You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services
If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal
If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal 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 Level 1 appeal, we'll 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 for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 1-833-570-6670 (TTY users call 711).**
- **Get free help** from your State Health Insurance Assistance Program (SHIP).
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at **1-833-570-6670** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)
  - For medical care or Part B drugs, your doctor can ask for 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.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf**. You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services at **1-833-570-6670** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at **1-833-570-6670** (TTY users call **711**). You can also get help or information from your State Health Insurance Assistance Program (SHIP).

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we have said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

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, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2

requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function*.
- **If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains that if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- 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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that

explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeals process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage 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 Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare.** It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll 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 the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal within **72 hours** of when it gets 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets 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 Part B drug.

Step 2: The independent review organization gives you its 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have 72 hours from the date we receive the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests**, we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 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 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us
If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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 asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **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. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells you what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing 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 pay as your share of the cost of the drug.

    - 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).
    - 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 can't ask us to change the cost-sharing tier for any drug in Tier 5 Specialty.
    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically 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're requesting and wouldn't cause more side effects or other health problems, we generally *won't* approve your request for an exception. If you ask us for a tiering exception, we generally *won't* 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 our 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, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal Term:

A fast coverage decision is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid

back for a drug you have already bought.)
- 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'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. 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 (**Aetna.com/medicare/contact-us/appeals-grievances.html**). Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reasons for the exception. 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.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination.**

A fast appeal is called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, 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 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Coverage Redetermination Request Form*, which is available on our website (**Aetna.com/medicare/contact-us/appeals-grievances.html**). Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include 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 and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all 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

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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 independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review 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 reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we

must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?
If this organization says no **to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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 is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-MEDICARE (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

   - Your right to get 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.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**

   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing this notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at **1-833-570-6670** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Member Services at **1-833-570-6670** (TTY users call **711**). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. Refer to **Appendix A** at the back of this document for the name and contact information of the State Health Insurance Assistance Program (SHIP) in your state.

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. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*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 **Appendix A** at the back of this document.

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.**
  - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at **1-833-570-6670** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**) TTY users call **1-877-486-2048**. Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) 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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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.

What happens if the answer is no?

- If the independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision 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.

Step 1: 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 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 the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for

that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
    - The date when we'll stop covering the care for you.
    - How to request a *fast-track appeal* to ask us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 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'll 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.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-833-570-6670 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Refer to **Appendix A** at the back of this document for the name and contact information of the State Health Insurance Assistance Program (SHIP) in your state.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got *(Notice of Medicare Non-Coverage)* tells you how to reach this

organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Appendix A** at the back of this document.

Act quickly:

- 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, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in **Appendix A** at the back of this document.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you its decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you**.
- 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'll 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.

- 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 a Level 2 appeal.

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar 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 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 the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4 and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll 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 medical care 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 the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll 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 don't want to accept the decision, you may 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal
A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal
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.** 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 get the decision.
- **If the answer is no, the appeals process *may or may not be over.***
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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.** 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 get the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may 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 will tell you whether the rules allow you to go on to Level 5 appeal. It 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.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our 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 our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting the deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Term:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly — either by phone or in writing.

- **Calling Member Services at 1-833-570-6670 (TTY users call 711) is usually the first step**. If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll 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 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.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem that you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll 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.
- **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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** 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. **Appendix A** at the back of this document has the contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about Aetna Medicare Value Plus (PPO) directly to Medicare. To submit a complaint to Medicare, go to **www.Medicare.gov/my/medicare-complaint**. You can also call 1-800-MEDICARE (**1-800-633-4227**). TTY/TDD users call **1-877-486-2048**.

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Aetna Medicare Value Plus (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **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, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan,
  - Original Medicare *without* a separate Medicare drug plan.
    - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

  Note: If you disenroll from Medicare 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.
- Your **membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period each year.**

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and for new enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **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 drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Aetna Medicare Value Plus (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period.**

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit **Medicare.gov**:

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're 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.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage
- Original Medicare *with* a separate Medicare drug plan
- Original Medicare *without* a separate Medicare drug plan.
  Note: If you disenroll from Medicare drug coverage and go without creditable 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.

Your membership will usually end on the first day of the month after we get your request to change our plan.

If you get Extra Help from Medicare to pay your drug coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-833-570-6670 (TTY users call 711).**
- Find the information in the ***Medicare & You 2026*** handbook.
- Call **Medicare** at 1-800-MEDICARE (**1-800-633-4227**). (TTY users call **1-877-486-2048**).

SECTION 3 How to end your membership in our plan?

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan.	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Aetna Medicare Value Plus (PPO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan.	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Aetna Medicare Value Plus (PPO) when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan.	• **Send us a written request to disenroll.** Call Member Services at 1-833-570-6670 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare**, at 1-800-MEDICARE (1-800-633-4227), and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Aetna Medicare Value Plus (PPO) when your coverage in Original Medicare starts.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services, and prescription drugs, through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Aetna Medicare Value Plus (PPO) must end our plan membership in certain situations

Aetna Medicare Value Plus (PPO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you're away from our service area for more than 12 months.

    - If you move or take a long trip, you need to call Member Services at 1-833-570-6670 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't 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 can't 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're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-833-570-6670 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Aetna Medicare Value Plus (PPO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?
If you feel that you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

Section 5.2 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.

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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 (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about non discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, 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, 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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **www.HHS.gov/ocr/index.html**.

If you have a disability and need help with access to care, call us at Member Services at **1-833-570-6670** (TTY users call **711**). 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 isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Aetna Medicare Value Plus (PPO), 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 (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or you can download a copy by visiting the **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 2026, 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.

CHAPTER 12:
Definitions

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 doesn't 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 got. You may also make an appeal if you disagree with our decision to stop services that you're receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Aetna Medicare Value Plus (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to balance bill or otherwise charge you more than the amount of cost sharing our 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 skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into 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.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to **"Original Biological Product"** and **"Biosimilar."**)

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (Go to ***"Interchangeable Biosimilar"***).

Brand Name Drug – A prescription drug that's 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.

Calendar Year – A one year period between January 1 and December 31.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4 Section 1.2 for information about your combined maximum out-of-pocket.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, 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 (for example $10), rather than a percentage.

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 3 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.

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 our plan and the amount, if any, you're 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 our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all 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's 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes 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're 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 our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible 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 (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. 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) provided 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 isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (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's approved by the 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 our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who 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).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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 Association (IPA) – 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 managed care organizations (see Chapter 1, Section 6).

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. 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.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered services received from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs), Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get 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 also available for a 3-month period after a person 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, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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 our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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.

Network – A group of doctors, hospitals, pharmacies, and other health care experts contracted by our plan to provide covered services to its members (go to Chapter 1, Section 3.2). Network providers are independent contractors and not agents of our plan.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

Network Provider – Provider is the general term 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. **Network providers** 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. Network providers are also called **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.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Optional Supplemental Benefits – Non-Medicare covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – A decision our plan makes 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 document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as 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 2 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. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to 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.

Out-of-Pocket Threshold – The maximum amount you pay out-of-pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's 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're first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but 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.

Quantity Limits – A management tool that is designed to limit the use of a drug 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.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. 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. Our plan must disenroll you if you permanently move out of our 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 care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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 live 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'll 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plan’s service area, or it’s unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.

APPENDIX A:
Important contact information

	Quality Improvement Organizations (QIO)
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	**Acentra Health**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-315-0636, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, **Website:** acentraqio.com

	State Medicaid Office
Texas	**Texas Medicaid Program**, **Address:** Health and Human Services (HHS), North Austin Complex, 4601 W. Guadalupe St., Austin, TX 78751-3146, PO Box 13247, Austin, Texas 78711-3247, **Phone:** 1-800-252-8263, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 6:00 PM, **Website:** hhs.texas.gov/services/health/medicaid-chip

	State Health Insurance Assistance Program (SHIP)
Texas	**Texas Health Information, Counseling and Advocacy Program (HICAP)**, **Address:** Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin TX 78751, **Phone:** 1-800-252-9240, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/medicare

	State Pharmaceutical Assistance Program (SPAP)
Texas	**Kidney Health Care Program (KHC)**, **Address:** Kidney Health Care, MC 1938, PO Box 149030, Austin, TX 78714-9947, **Phone:** 1-800-222-3986, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/kidney-health-care
	State AIDS Drug Assistance Programs (ADAP)
Texas	**Texas HIV Medication Program (THMP)**, **Address:** Texas Health and Human Services, ATTN: MSJA, MC 1873, PO Box 149347, Austin, TX 78714-9347, **Phone:** 1-800-255-1090, 737-255-4300, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dshs.texas.gov/hivstd/meds

Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on your ID card. (English)

እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ በመታወቂያ ካርድዎ (ID) ላይ ወዳለው ቁጥር ይደውሉ። (Amharic)

(Arabic) صول على خدمات اللغة مجانًا، اتصل بالرقم الموجود على بطاقة العضوية الخاصة بك.

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa Waraqaa Eenyummeessaa (ID) keessan irra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro figurant sur votre carte d'identité. (French)

Pou w jwenn aksè ak sèvis lang gratis pou ou, rele nimewo ki sou kat idantite w la. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer auf Ihrem Ausweis an. (German)

Inā ake ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe i ka helu ma kou kāleka ID. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj nyob ntawm koj daim npav ID. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato sul tuo tesserino identificativo. (Italian)

無料の言語サービスをご利用いただくには、ご自身のIDカードに記載されている番号 にお電話ください。 (Japanese)

လၢကမၤနၢ် ကျဒီတၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢ်ဘူၣ်လၢ်စုၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ လၢအအိၣ် ဖဲန ID အဖီခိၣ်နၣ် တကွၢ်. (Karen)

무료로 언어 서비스를 이용하려면 ID 카드에 적힌 전화번호로 전화하세요. (Korean)

ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບ ເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ, ໃຫ້ໂທຫາເບີ ທີ່ຢ່ຍໃນ ບັດປະ ຈຳ ຕົວຂອງທ. (Laotian)

ដើម៊ីទទួល នេស ផែ ក េយមិនគិតៃថ ពីអ កសូមទូរសព េលេខែដល នេ លើ តស ល់ខ នរបស់អ ក។ (Mon-Khmer, Cambodian)

(Persian farsi) برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany na karcie ID. (Polish)

Ligue para o número que está no seu cartão de identificação para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному на вашей идентификационной карте. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que figura en su tarjeta de identificación. (Spanish)

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa iyong ID card. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại trên thẻ ID của quý vị. (Vietnamese)

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Aetna Medicare Value Plus (PPO) Member Services

	Member Services – Contact Information
Call	1-833-570-6670 or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services at 1-833-570-6670 (TTY users call 711) 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 14088 Lexington, KY 40512
Website	Go to AetnaMedicare.com/H3288-018 or scan this code with your smartphone to visit our website.

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 **Appendix A** at the back of this document.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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