Aetna Medicare FIDE (HMO D-SNP) *Evidence of Coverage*

January 1, 2027 – December 31, 2027

Your Health and Drug Coverage under Aetna Medicare FIDE (HMO D-SNP)

Evidence of Coverage Introduction

This *Evidence of Coverage*, otherwise known as the *Member Handbook*, tells you about your coverage under our plan through December 31, 2027. It explains health care services, including behavioral health (mental health and substance use disorder treatment) services, drug coverage, and Managed Long-Term Services and Supports (MLTSS). Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Evidence of Coverage*.

This is an important legal document. Keep it in a safe place.

When this *Evidence of Coverage* says "we," "us," "our," or "our plan," it means Aetna Medicare FIDE (HMO D-SNP).

This document is available for free in Spanish. Este documento está disponible de forma gratuita en español.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

- Aetna Medicare FIDE (HMO D-SNP) wants to make sure you understand your health plan information. If a different language or format works better for you, call Member Services at the number listed at the bottom of this page to request a change.
- We will continue sending you mailings and other communications in your requested format. (This is called a "standing request.")
- If you want to change your standing request for a preferred language or format, call Member Services.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at **1-844-362-0934** (**TTY: 711**). Someone that speaks Spanish can help you. This is a free service.

OMB Approval 0938-1444 (Expires: 5/31/2029)

Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on this document. (English)

እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ በዚህ ሰነድ ላይ ወዳለዉ ቁጥር ይደውሉ። (Amharic)

للحصول على خدمات اللغة مجانًا، اتصل بالرقم المذكور في هذه الوثيقة. (Arabic)

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa doookumentii kanarra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro indiqué sur ce document. (French)

Pou jwenn sèvis lang san ou pa peye anyen, rele nimewo ki sou dokiman sa a. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer in diesem Dokument an. (German)

Inā ake ‘oe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ‘oe i ka helu ma kēia palapala. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj ntawm daim ntawv no. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato in questo documento. (Italian)

無料の言語サービスをご利用いただくには、この書類に記載されている番号にお電話ください。 (Japanese)

လၢကမၤနၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လာ်ဘူၣ်လာ်စုၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီလံာ်မီအံၤအဖီခိၣ်နၣ်တကုၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພ່ ອ ້ ເ ຂາເ ຖ້ງການ ບໍ່ວການພາສາໂດຍ ບເສຍຄ່ າໃ ຊ້ຈ່ າຍໃດໆ, ໃຫ້ ໂທຫາເ ບີ້ໂທໃນເອກະສານ ີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

Ligue para o número indicado neste documento para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному в этом документе. (Russian)

If you have questions, please call Aetna Medicare FIDE (HMO D-SNP) Member Services at **1-844-362-0934** (TTY: **711**), 8 AM to 8 PM, 7 days a week. The call is free. **For more information**, visit **AetnaMedicare.com/NJDSNP**.

Para acceder a servicios de idiomas sin costo alguno, llame al número que aparece en este documento. (Spanish)

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa dokumentong ito. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)

Y0001_Y0130_H6399_2025_V3

2027 EVIDENCE OF COVERAGE

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1: Getting started as a member **6**
Chapter 2: Important phone numbers and resources **14**
Chapter 3: Using our plan's coverage for your health care and other covered services **23**
Chapter 4: Benefits Chart **39**
Chapter 5: Getting your outpatient drugs **97**
Chapter 6: What you pay for your Medicare and NJ FamilyCare (Medicaid) drugs **112**
Chapter 7: Asking us to pay a bill you got for covered services or drugs **118**
Chapter 8: Your rights and responsibilities **123**
Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) **134**
Chapter 10: Ending your membership in our plan **168**
Chapter 11: Legal notices **177**
Chapter 12: Definitions of important words **179**

Disclaimers

- Benefits may change on January 1, 2028.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.
- Aetna Medicare FIDE (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the New Jersey Medicaid Program. Enrollment in Aetna Medicare FIDE depends on contract renewal.
- See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage.
- When joining this plan:
    1. You must use in-network providers, DME (Durable Medical Equipment) suppliers, and pharmacies.
    2. You will be enrolled automatically into Medicaid (NJ FamilyCare) coverage under our plan, and disenrolled from any Medicaid (NJ FamilyCare) plan you are currently enrolled in. All of your Medicaid-covered services, items, and medications will then be covered under our plan, and you must get them from in-network providers.
    3. You will be enrolled automatically into Part D coverage under our plan, and you will be automatically disenrolled from any other Medicare Part D or creditable coverage plan in which you are currently enrolled.
    4. You must understand and follow our plan's rules on referrals.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Aetna Medicare FIDE (HMO D-SNP), a health plan that covers all of your Medicare and NJ FamilyCare (Medicaid) services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

Table of Contents

Chapter 1 Getting started as a member

A. Welcome to our plan 7
B. Information about Medicare and NJ FamilyCare (Medicaid) 7
B1. Medicare 7
B2. NJ FamilyCare 7
C. Advantages of our plan 7
D. Our plan's service area 8
E. What makes you eligible to be a plan member 8
F. What to expect when you first join our health plan 9
G. Your care team and care plan 9
G1. Care team 9
G2. Care plan 9
H. Summary of Important Costs 9
H1. Monthly Medicare Part B premium 10
I. This Evidence of Coverage 10
J. Other important information you get from us 10
J1. Your Member ID Card 10
J2. *Provider and Pharmacy Directory* 11
J3. *List of Covered Drugs* 11
J4. The *Explanation of Benefits* 12
K. Keeping your membership record up to date 12
K1. Privacy of personal health information (PHI) 13

A. Welcome to our plan

Our plan provides Medicare and NJ FamilyCare (Medicaid) services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have Care Managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

B. Information about Medicare and NJ FamilyCare (Medicaid)

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. NJ FamilyCare

NJ FamilyCare is the name of the New Jersey Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. NJ FamilyCare helps people with limited incomes and resources pay for MLTSS and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of New Jersey approved our plan. You can get Medicare and NJ FamilyCare services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of New Jersey allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and NJ FamilyCare services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and NJ FamilyCare services from our plan, including drugs. **You don't pay anything to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a Care Manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and Care Manager.
- Your care team and Care Manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in **New Jersey**: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Evidence of Coverage* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or national, or an eligible non-citizen, **and**
- are currently eligible for NJ FamilyCare.

If you lose your NJ FamilyCare eligibility but can be expected to regain it within three months, we'll continue to provide all Medicare and NJ FamilyCare covered benefits. During this time, we'll assist you to regain NJ FamilyCare eligibility. If you can't regain NJ FamilyCare eligibility within three months we'll disenroll you from Aetna Medicare FIDE (HMO D-SNP). If you regain NJ FamilyCare eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs, including but not limited to: walking, bathing, eating, toileting, and dressing.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail. We'll reach out to you annually to see if any of your needs have changed.

We'll send you more information about this HRA.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a Care Manager, your specialists, or other health professionals that you choose.

A Care Manager is a person trained to help you manage the care you need. You get a Care Manager when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the number at the bottom of the page for more information about your Care Manager and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and MLTSS or other services. Your care plan includes:

- your HRA findings,
- gaps in your care,
- your preferences to ensure you receive care based on your needs,
- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Summary of Important Costs

Our plan has no premium.

H1. Monthly Medicare Part B premium

Medicaid pays your Medicare Part B premium for you when you're enrolled in this plan.

I. This *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an *Evidence of Coverage* by calling Member Services at the number at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website at the web address at the bottom of the page.

The contract is in effect for the months you're enrolled in our plan between January 1, 2027 and December 31, 2027.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory,* and information about how to access a *List of Covered Drugs,* also known as a *Drug List.*

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and NJ FamilyCare services, including MLTSS, behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or

your NJ FamilyCare card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Evidence of Coverage* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

The *Provider and Pharmacy Directory* lists our network providers, durable medical equipment suppliers, and network pharmacies. The online *Provider and Pharmacy Directory* lists information of all network providers, including names, addresses, phone numbers, specialties and qualifications, board certification status and more. You can also search our providers on the **HealthGrades.com** website to get more information, such as medical school attended and residency completion.

Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - MLTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. 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've been removed and replaced as

described in **Chapter 5, Section E** Medicare approved the Aetna Medicare FIDE (HMO D-SNP) *Drug List*.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take. **Chapter 6** of this *Evidence of Coverage* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the number at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Evidence of Coverage*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your Care Manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

Table of Contents

Chapter 2 Important phone numbers and resources

A. Member Services 15
B. Your Care Manager 16
C. State Health Insurance Assistance Program (SHIP) 17
D. Quality Improvement Organization (QIO) 18
E. Medicare 18
F. NJ FamilyCare (Medicaid) 19
G. Office of the Insurance Ombudsman 20
H. New Jersey Office of the State Long-Term Care Ombudsman 20
I. Programs to Help People Pay for Drugs 20
I1. Extra Help from Medicare 21
J. Social Security 21
K. Railroad Retirement Board (RRB) 21
L. Group insurance or other insurance from an employer 22

A. Member Services

CALL	1-844-362-0934 (**TTY:** 711). This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week.
WRITE	Aetna Medicare FIDE (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	AetnaMedicare.com/NJDSNP

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this *Evidence of Coverage.*
- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Evidence of Coverage* or contact Member Services.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D**).
  - You can call us and explain your complaint at 1-844-362-0934 (**TTY:** 711).
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can contact the state's Medicaid program with a complaint by calling the NJ Department of Human Services, Division of Medical Assistance & Health Services at 1-800-701-0710 (**TTY:** 711).
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Evidence of Coverage*.
- coverage decisions about your drugs

    - A coverage decision about your drugs is a decision about:
        - your benefits and covered drugs.
    - This applies to your Medicare Part D drugs and NJ FamilyCare covered drugs and over-the-counter drugs.
    - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.
- appeals about your drugs
    - An appeal is a way to ask us to change a coverage decision.
    - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.
- complaints about your drugs
    - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
    - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above)
    - You can send a complaint about our plan to Medicare. You can use an online form at **www.medicare.gov/my/medicare-complaint**. Or you can call 1-800-MEDICARE (**1-800-633-4227**) to ask for help.
    - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.
- payment for health care or drugs you already paid for
    - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Evidence of Coverage*.
    - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Evidence of Coverage*.

B. Your Care Manager

Care Managers can help with your special health care needs. They are nurses, social workers and licensed counselors, and they understand your health conditions. They work with your doctors to help get you the care that you need. After you are enrolled, a Care Manager will be assigned to you.

If you would like to get connected to your Care Manager, call Member Services at **1-844-362-0934** (**TTY: 711**). Your Care Manager is available from 8 AM to 5 PM Monday through Friday.

If you would like to request a new Care Manager, just call Member Services at **1-844-362-0934** (**TTY: 711**). We're here for you 8 AM to 8 PM, 7 days a week.

CALL	**1-844-362-0934** (**TTY: 711**). This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	**711**. This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week.

WRITE	Aetna Medicare FIDE (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998

Contact your Care Manager to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder treatment) services
- questions about transportation
- questions about Managed Long Term Services and Supports (MLTSS)

C. 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. In New Jersey, the SHIP is called the State Health Insurance Assistance Program (SHIP).

The 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.

CALL	**1-800-792-8820** Monday–Friday 8:30 AM to 4:30 PM
TTY	**711**
WRITE	NJ State Health Insurance Assistance Program PO Box 807 Trenton, NJ 08625
WEBSITE	**nj.gov/humanservices/doas/services/q-z/ship/**

Contact SHIP for help with:

- questions about Medicare
- SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Commence Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

CALL	1-866-815-5440
TTY	711
WRITE	**BFCC-QIO Program** Commence Health PO Box 2687 Virginia Beach, VA 23450
WEBSITE	https://www.commencehealthqio.cms.gov/en/contact-information?state=New%20Jersey

Contact Commence Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

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 call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
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. 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.

F. NJ FamilyCare (Medicaid)

NJ FamilyCare helps with medical and long-term services and supports costs for people with limited incomes and resources.

You're enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the NJ Department of Human Services, Division of Medical Assistance & Health Services.

Because you're eligible for and enrolled in both Medicare and Medicaid, your coverage through our plan includes coverage for all of the benefits you're entitled to under Medicaid managed care NJ FamilyCare. As a result, Aetna Medicare FIDE (HMO D-SNP) covers all of your Medicaid benefits, such as hearing aids, routine vision exams, and comprehensive dental services. Additionally, Medicaid pays your Part B premium for you.

CALL	NJ Department of Human Services, Division of Medical Assistance & Health Services **1-800-701-0710** Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM
TTY	**711**
WRITE	NJ Department of Human Services Division of Medical Assistance and Health Services PO Box 712 Trenton, NJ 08625-0712

WEBSITE	state.nj.us/humanservices/dmahs/

G. Office of the Insurance Ombudsman

The Office of the Insurance Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Insurance Ombudsman also helps you with service or billing problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-800-446-7467 Monday–Friday 9:00 AM to 5:00 PM
TTY	711
WRITE	The Office of the Insurance Ombudsman NJ Department of Banking and Insurance PO Box 472 Trenton, NJ 08625-0472
WEBSITE	nj.gov/dobi/ombuds.htm

H. New Jersey Office of the State Long-Term Care Ombudsman

The New Jersey Office of the State Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The New Jersey Office of the State Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

CALL	1-877-582-6995 Monday–Friday 8:30 AM to 4:30 PM
TTY	711
WRITE	NJ Long-Term Care Ombudsman PO Box 852 Trenton, NJ 08625-0852
WEBSITE	nj.gov/ooie/

I. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

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 call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	Medicare.gov

J. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	SSA.gov

K. Railroad Retirement Board (RRB)

The RRB 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 RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	**1-877-772-5772** Calls to this number are free. Press "0", to speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1", to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	**www.rrb.gov**

L. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at the phone number at the bottom of the page with any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can also 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's 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's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your Care Management, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

Table of Contents

Chapter 3 Using our plan's coverage for your health care and other covered services

A. Information about services and providers **25**

B. Rules for getting services our plan covers **25**

C. Your Care Manager **26**

- **C1. What a Care Manager is** **26**
- **C2. How you can contact your Care Manager** **26**
- **C3. How you can change your Care Manager** **26**

D. Care from providers **26**

- **D1. Care from a primary care provider (PCP)** **26**
- **D2. Care from specialists and other network providers** **28**
- **D3. When a provider leaves our plan** **28**
- **D4. Out–of–network providers** **29**

E. Managed Long-term services and supports (MLTSS) **30**

F. Behavioral health (mental health and substance use disorder treatment) services **30**

G. How to get self–directed care through the Personal Preference Program (PPP) **31**

- **G1. What self–directed care is** **31**
- **G2. Who can get self–directed care (for example, if it's limited to waiver populations)** **31**
- **G3. How to get help in employing personal care providers (if applicable)** **31**

H. Transportation services **31**

I. Covered services in a medical emergency, when urgently needed, or during a disaster **32**

- **I1. Care in a medical emergency** **32**

I2. Urgently needed care 33
I3. Care during a disaster 34
J. What if you're billed directly for covered services 34
J1. What to do if our plan doesn't cover services 34
K. Coverage of health care services in a clinical research study 35
K1. Definition of a clinical research study 35
K2. Payment for services when you're in a clinical research study 35
K3. More about clinical research studies 35
L. How your health care services are covered in a religious non–medical health care institution 36
L1. Definition of a religious non–medical health care institution 36
L2. Care from a religious non–medical health care institution 36
M. Durable medical equipment (DME) 36
M1. DME as a member of our plan 36
M2. DME ownership if you switch to Original Medicare 37
M3. Oxygen equipment benefits as a member of our plan 37
M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan 37

A. Information about services and providers

Services are health care, Managed Long-Term Services and Supports (MLTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and MLTSS are in **Chapter 4** of this *Evidence of Coverage*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Evidence of Coverage*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain MLTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and NJ FamilyCare. This includes behavioral health and Managed Long-Term Services and Supports (MLTSS).

Our plan will generally pay for health care services, behavioral health services, and MLTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Evidence of Coverage.*
- The care must be **medically necessary.** By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (go to **Section D1** for more information).
    - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (go to **Section D1** for more information).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for the services you get. Here are some cases when this rule doesn't apply:
    - If you need emergency or urgently needed care from an out-of-network provider (for more information go to **Section I**).
    - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Prior authorization should be obtained from the plan prior to seeking care. In this situation, we cover the care at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4**.

- If you need kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible, you can get care from an out-of-network provider. If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

C. Your Care Manager

C1. What a Care Manager is

A Care Manager is a trained person who works for our plan to make sure you get the health care you need. A Care Manager, along with others on the care team, will work with you to complete health risk assessments in order to create your personal care plan. Your Care Manager will also help you obtain benefits, coordinate appointment scheduling, and assist with accessing community resources and support.

We're here to support you whether you need a routine checkup, help managing a condition or answers about your benefits. Find out what's available to you so you know where to turn to for care and support by visiting **AetnaMedicare.com/NJDSNP**. You can also visit our Health Programs (**https://www.aetnabetterhealth.com/new-jersey-hmosnp/population-health-programs.html**) webpage to learn more about programs and services designed to help you stay healthy and manage your health care needs.

C2. How you can contact your Care Manager

A Care Manager will be assigned to you when you become a member. Your Care Manager will contact you when you enroll in the plan. Members can be referred to the complex Care Management program from a variety of sources, including our medical management programs, discharge planners, members, caregivers and providers.

For more information on being referred to Care Management or contacting your Care Manager, call **1-844-362-0934** (**TTY:711**) or visit online at **https://www.aetnabetterhealth.com/new-jersey-hmosnp/whats-covered.html**.

C3. How you can change your Care Manager

If you would like to change your Care Manager, please contact our Member Services department at the number at the bottom of this page.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does do for you

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

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

- General Practitioner
- Internist
- Family Practitioner
- Geriatrician
- Physician Assistants
- Nurse Practitioners

Please refer to your *Provider and Pharmacy Directory* or go to our website at **AetnaMedicare.com/NJDSNP-find-provider** for a complete listing of PCPs in your area.

What is the role of a PCP in coordinating covered services?
Your PCP will provide most of your care, and when you need more specialized services, they will coordinate with other providers. Your PCP 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?
In some cases, your PCP (or other provider), or you as the plan member, may need to request advance approval from our Medical Management Department for certain types of services or tests. This is called getting **prior authorization**. **Chapter 4** lists the services and items that require **prior authorization**.

Your choice of PCP
You can select your PCP by using the *Provider and Pharmacy Directory,* by accessing our website at **AetnaMedicare.com/NJDSNP-find-provider**, or getting help from Member Services.

If you have not selected a PCP, a PCP will be selected for you. You can change your PCP (as explained later in this section) for any reason, and at any time, by contacting Member Services.

Option to change your PCP
You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

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. They will also send you a new membership card that shows the name and/or phone number of your new PCP.

Under certain circumstances, you may continue receiving covered services from a participating physician or other health care professional who has left the network for up to four months beyond the effective date of termination (the end of the notice period).

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- Pregnancy – up to the postpartum evaluation (up to six weeks after delivery)
- Post-operative follow-up care (up to six months)
- Oncological treatment (up to one year)
- Psychiatric treatment (up to one year)

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

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

What is the role of the PCP in referring members to specialists and other providers?
Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member.

- Your PCP may refer you to a specialist, but you can go to any specialist in our network without a referral. Please refer to the *Provider and Pharmacy Directory* or access our website at **AetnaMedicare.com/NJDSNP-find-provider** for a complete listing of PCPs and other participating providers in your area.

What is the role of the PCP in making decisions about or obtaining prior authorization?
In some cases, your PCP (or other provider), or you as the plan member, may need to request advance approval from our Medical Management Department for certain types of services or tests. This is called getting **prior authorization**. **Chapter 4** lists the services and items that require **prior authorization**.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select 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 three 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 three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- Under certain circumstances, you may continue receiving covered services from a provider who has left our network for up to four months beyond the effective date of termination (the end of the notice period).
- If you're currently 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. If you're undergoing certain courses of treatment, you may be able to receive longer periods of care as indicated below:
  - Pregnancy (up to the postpartum evaluation): up to six weeks after delivery.
  - Post-operative follow-up care (care given after surgery): up to six months.
  - Oncological treatment (treatment for cancer): up to one year.
  - Psychiatric treatment (mental health treatment with a psychiatrist): up to one year.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization should be obtained from the plan prior to seeking care.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

Under certain circumstances, for up to four months beyond the effective date of termination (the end of the notice period), you may continue receiving covered services from a provider who has left our network.

Additionally, if you're undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- pregnancy – up to the postpartum evaluation (up to six weeks after delivery)
- post-operative follow-up care (up to six months)
- oncological treatment (up to one year)
- psychiatric treatment (up to one year)

D4. Out–of–network providers

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

four exceptions:

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider.
- If you need medical care that Medicare or NJ FamilyCare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior authorization should be obtained from the plan prior to seeking care. Your PCP or other network provider will contact us to obtain authorization for you to see an out-of-network provider.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- You may receive Family Planning services through out-of-network providers. In these cases, the services will be covered directly through Medicaid fee-for-service.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or NJ FamilyCare.

- We can't pay a provider who isn't eligible to participate in Medicare and/or NJ FamilyCare.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Managed Long-term services and supports (MLTSS)

The MLTSS program provides home- and community-based services for members that require the level of care typically provided in a nursing facility and allows them to receive necessary care in a residential or community setting.

MLTSS services include (but are not limited to): assisted living services; cognitive, speech, occupational, and physical therapy; chore services; personal emergency response systems; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and non-medical transportation. MLTSS is available to members who meet certain clinical and financial requirements. If you would like more information, or to ask for an assessment to determine your eligibility for MLTSS, call your Care Manager at **1-844-362-0934** (**TTY: 711**), 8 AM to 5 PM, Monday through Friday.

F. Behavioral health (mental health and substance use disorder treatment) services

Your plan covers a number of behavioral health benefits for you. Behavioral health includes both mental health services and substance use disorder treatment services. You will find details in the Benefits Chart in **Chapter 4**.

When requesting prior authorization or making arrangements to receive behavioral health services members and providers should call Member Services at **1-844-362-0934** (**TTY: 711**).

G. How to get self–directed care through the Personal Preference Program (PPP)

G1. What self–directed care is

The New Jersey Personal Preference Program (PPP) offers a way for NJ FamilyCare members who qualify for Personal Care Assistant (PCA) services to direct and manage the PCA services.

G2. Who can get self–directed care (for example, if it's limited to waiver populations)

PCA services are non-emergency, health related tasks through NJ FamilyCare. Tasks include help with activities of daily living (ADLs) and with household duties essential to the patient's health and comfort, such as bathing, dressing, meal preparation, and light housekeeping.

G3. How to get help in employing personal care providers (if applicable)

You get to choose who you hire to provide PCA services. You can hire a relative, friend or neighbor. Ask your Care Manager for help with this process. If you need help choosing services, or your PCA, you can choose someone you trust to decide for you.

You also will work with a financial counselor to make a plan to manage payment to your PCA.

To take part in PPP, you need to be:

1. Approved for Personal Care Assistant Services (PCA), and need PCA services for at least six months.
2. Able to direct and manage your services or choose someone to decide for you

If you would like to request a PCA assessment for enrollment into PPP, please contact your Care Manager at **1-844-362-0934** (**TTY: 711**) 8 AM to 5 PM, Monday through Friday.

H. Transportation services

Medicaid Fee-for-Service covers most non-emergency transportation services and arranges these services through the state's transportation vendor, Modivcare. Covered transportation may include Mobile Assistance Vehicles (MAVs), non-emergency Basic Life Support (BLS) stretcher ambulance transportation, and livery transportation services, such as bus or train fares and passes, car services, and mileage reimbursement when eligible.

In addition, we cover some limited non-emergency ambulance services under your plan's part B medical benefits when you have an order from your doctor stating that ambulance transportation is medically necessary. Coverage only applies for transportation to the nearest appropriate facility that can provide the required services.

To schedule Medicaid-covered transportation, call Modivcare at **1-866-527-9933**. You may also ask your Primary Care Provider (PCP) or Care Manager to help arrange transportation. For more information about transportation benefits, please contact your Care Manager or Member Services at **1-844-362-0934** (**711**).

Member Services is available 7 days a week, from 8:00 AM to 8:00 PM.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- in the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible**. Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, tell our plan about your emergency.** We 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 at **1-844-362-0934** (TTY: **711**). Hours of operation are 8 AM to 8 PM, 7 days a week.

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 Benefits Chart in **Chapter 4** for more information. Be sure to get a copy of all your medical records from your emergency 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.

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. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

Post-stabilization care means the covered services related to an emergency medical condition that are provided after your emergency medical condition has been stabilized.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency
Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area
In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

If you need to locate an urgent care facility, you can find an in-network urgent care center near you by using the *Provider and Pharmacy Directory*, going to our website at **AetnaMedicare.com/NJDSNP-find-provider**, or getting help from Member Services.

Urgently needed care outside our plan's service area
When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. 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.

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 Benefits Chart in **Chapter 4** for more information. Be sure to get a copy of all your medical records from your emergency 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.

I3. 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 our website for information on how to get care you need during a declared disaster: **AetnaMedicare.com/NJDSNP**.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

J. What if you're billed directly for covered services

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this *Evidence of Coverage* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

J1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Evidence of Coverage*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *Evidence of Coverage* explains what to do if you want us to cover a medical service or

item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be 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 want to take part in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study don't need to be network providers. 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.

We encourage you to tell us before you take part in a clinical research study.
If you plan to be in a clinical research study covered for enrollees by Original Medicare, we encourage you or your Care Manager to contact Member Services to let us know you'll take part in a clinical trial.

K2. Payment for services when you're in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare or our plan **hasn't** approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website **www.medicare.gov/coverage/clinical-research-studies**. You can also call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

L. How your health care services are covered in a religious non–medical health care institution

L1. Definition of a religious non–medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. 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 against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **not voluntary and 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:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

Please see the Benefits Chart in **Chapter 4** for more information about inpatient hospital coverage and limitations.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME, no matter how long you rent it.

In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the number at the bottom of the page for more information.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you won't own the equipment.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, those **Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to five years if medically necessary

If oxygen equipment is still medically necessary **at the end of the five-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new five-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every five years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

Table of Contents

Chapter 4 Benefits Chart

A. Your covered services **40**

B. Rules against providers charging you for services **40**

C. About our plan's Benefits Chart **40**

D. Our plan's Benefits Chart **44**

E. Benefits covered outside of our plan **95**

F. Benefits not covered by our plan, Medicare, or NJ FamilyCare **95**

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Evidence of Coverage.* This chapter also explains limits on some services.

Because you get assistance from NJ FamilyCare, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Evidence of Coverage* for details about the plan's rules.

If you need help understanding what services are covered, call your Care Manager and/or Member Services at **1-844-362-0934** (**TTY: 711**).

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this *Evidence of Coverage* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. (Drug coverage is in **Chapter 5.**) It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You don't pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and NJ FamilyCare covered services according to the rules set by Medicare and NJ FamilyCare.
- The services (including medical care, behavioral health and substance use disorder treatment services, Managed Long Term Services and Supports (MLTSS), supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get. **Chapter 3** of this *Evidence of Coverage* has more information about using network and out-of-network providers.

- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with bold type.
- If our plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your Medicare & You 2027 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**.)
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- If you lose your NJ FamilyCare eligibility but can be expected to regain it within three months, we'll continue to provide all Medicare and NJ FamilyCare covered benefits. During this time, we'll assist you to regain NJ FamilyCare eligibility. If you can't regain NJ FamilyCare eligibility within three months we'll disenroll you from Aetna Medicare FIDE (HMO D-SNP). If you regain NJ FamilyCare eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.
- All preventive services are free. This apple shows the preventive services in the Benefits Chart.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have 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
    - Psoriasis
    - 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
- You must also be at high risk of hospitalization or other adverse health outcomes and require intensive care coordination.
- Eligibility will be determined based on your medical and pharmacy claims, and other clinical information. For information about the eligibility requirements to receive this benefit, visit **aet.na/NJQualify**.
- For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

D. Our plan's Benefits Chart

	Covered Service	What you pay and any additional requirements
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening 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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	$0
	Acupuncture We pay for acupuncture visits if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; • not associated with pregnancy. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • 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.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Acupuncture *(continued)*	
	Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
	Aetna® Medicare Extra Benefits Card You get an Aetna Medicare Extra Benefits Card to help pay for certain everyday expenses and support your overall health and wellness. On this card you can get: An Over-the-Counter (OTC) Wallet with a monthly benefit amount (allowance). See the **Over-the-Counter (OTC) Wallet** section in Chapter 4 for more details. If you are diagnosed with one or more qualifying chronic conditions and meet all other criteria, you may be eligible to use the monthly benefit amount on additional spending categories. See the **Special Supplemental Benefits for the Chronically Ill** row in this chart for more details. **Important:** • The Aetna Medicare Extra Benefits Card does not replace your member ID card. • If you received an Aetna Medicare Extra Benefits Card in 2026 and have not changed plans, you **will not** receive a new card for the 2027 plan year. Be sure to keep your card. • If you are a new member or were not enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026, 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. • If you had a plan with an Aetna Medicare Extra Benefits Card in 2026 and 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 Aetna has your 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.	$0 The Aetna Medicare Extra Benefits Card can only be used at authorized participating retail stores and online or by phone through CVS Flex Benefits™.
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Aetna Medicare Extra Benefits Card *(continued)*	
	• Investigations into reported fraud may take approximately 60-90 days to complete. Please note that reinstatement of funds is subject to the outcome of the investigation and is not guaranteed. • The card can only be used at authorized participating retailers that accept Visa®. Find an authorized participating retailer by visiting **CVS.com/Aetna** or by using the CVS Flex Benefits™ app. • The card cannot be used to pay for prescription drugs or products such as alcohol, tobacco, cannabis, firearms, lottery, and gift cards. • The card can only be used to pay for eligible 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). • Unused funds will be forfeited. No exceptions will be made to replace unused funds due to a lost or stolen card, personal circumstances, or failure to provide your accurate mailing address to Aetna. • For more information or if you need to request a replacement card, call **1-844-428-8147** (**TTY: 711**) 7 days a week, 8 AM - 8 PM local time excluding federal holidays. You can also use the CVS Flex Benefits app or visit **CVS.com/Aetna**.	
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of	$0 **Prior authorization is required for non-emergency transportation.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Ambulance services *(continued)*	
	getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	
	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
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0
	Autism Spectrum Disorder services For all members with an Autism Spectrum Disorder (ASD) diagnosis, we pay for: • Applied Behavioral Analysis (ABA) • augmentative and alternative communication services and devices	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Autism Spectrum Disorder services *(continued)*	
	• Sensory Integration (SI) services • allied health services (physical therapy, occupational therapy, and speech therapy) • Developmental, Individual-differences, and Relationship-based (DIR) services, including but not limited to DIR Floortime and the Greenspan approach therapy	
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and over • clinical breast exams once every 12 months	$0
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months • coronary artery bypass surgery • stable angina pectoris (chest pain) • heart valve repair or replacement	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Cardiac (heart) rehabilitation services *(continued)*	
	• coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • heart or heart and lung transplant • stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have two sessions per day (each lasting one hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0
	Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease annually for all members 20 years of age or older, and more frequently if medically necessary. These blood tests also check for defects due to high risk of heart disease.	$0
	Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 12 months	$0
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Chiropractic services *(continued)*	
	• clinical laboratory services • certain medical supplies • durable medical equipment • prefabricated orthoses • physical therapy services • diagnostic radiological services when they're prescribed by a chiropractor within their scope of practice	
	Community-Based Palliative Care (CBPC) The Community-Based Palliative Care (CBPC) program supports members with serious health conditions. It focuses on easing symptoms, coordinating care, and helping you and your family navigate the health system, while you keep getting your regular treatments. Care is provided at home or in other community places (not in a hospital) by an interdisciplinary care team creates a care plan based on your needs and goals. Depending on your individual needs, services may include: • help managing symptoms • home visits from nurses, social workers, or other licensed providers • help with planning for future care needs • coordinating and connecting you to other services • emotional, social, and spiritual support for you and your caregivers • reviewing and adjusting medications • guidance and support for caregivers • access to a 24/7 telephone line for urgent questions or concerns **Please note:** Palliative care and hospice care are different, and you **don't** need to have a terminal diagnosis to get palliative care. Palliative care can help anyone with a serious illness who is having a hard time with daily activities or managing their health. You can still get other medical treatments and keep seeing your regular doctor while receiving palliative care. **Member eligibility criteria** To be considered eligible for CBPC, you must have a serious	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Community-Based Palliative Care (CBPC) *(continued)*	
	illness and signs that it has affected your daily life. Examples of qualifying serious illnesses and changes in daily life are listed below. Your health plan may also approve CBPC if it decides the service is medically necessary for you. Diagnosis with serious illness: Eligible conditions include (but aren't limited to): Adult: • Cancer (Stage III or IV) • Congestive Heart Failure • COPD • ESRD or chronic kidney disease • Cirrhosis or liver disease • Degenerative neural condition (i.e., Parkinson's, severe neurodegenerative disorders) • Alzheimer's and dementias • Diabetes • Stroke • AIDS Pediatric: • Cardiac Disease • Pulmonary Disease • Neurological Disorder • Cancer • Renal Disease • End-stage Liver Disease • Genetic Disorders • Metabolic/Inclusion Disease • Gastrointestinal Disease or Conditions • Orthopedic Disorders • Neonatal • Infectious Disease Quality of life impairment, as indicated by one of the following: • Documented decline in ability to do daily activities	
	This benefit is continued on the next page.	

Covered Service	What you pay and any additional requirements
Community-Based Palliative Care (CBPC) *(continued)*	
• Recent acute care use: two or more emergency room visits in the last six months, or at least one hospital stay in the last 12 months • Other signs of functional decline or serious disease not listed above **Accessing Services** There are several ways to get CBPC services: • You (or someone helping you, like your provider, family member, or a community group) can use the Program Eligibility Screening Tool, then contact Aetna Medicare FIDE (HMO D-SNP) for next steps; if the screen shows you may qualify, Aetna Medicare FIDE (HMO D-SNP) can help you find an in-network provider for an assessment • Your healthcare provider or your health plan can also refer you directly for an assessment In either case, eligibility is confirmed with a Comprehensive Medical Assessment using the state's standard tool. This is done in-person by a qualified, Medicaid-enrolled clinician. To learn more about the program and whether you qualify, please reach out to**1-844-362-0934**(**TTY: 711**). Prior authorization is not needed for the assessment. If you're eligible, Aetna Medicare FIDE (HMO D-SNP) will approve services and start care planning with your palliative care team. To stay in the CBPC program, you'll be reassessed every six months, or sooner if your health changes a lot. If you still qualify, your approval will be extended for another six months. **Service Coordination** If you join CBPC, Aetna Medicare FIDE (HMO D-SNP) will assign a Care Manager (if you don't already have one). The Care Manager works with your palliative care team to coordinate services that support your palliative care plan – for example, Personal Care Assistance, home health, or needed equipment. Your palliative care team will meet at least once a month to review your needs and update the care plan, and at least one of these monthly meetings will include your Aetna Medicare FIDE (HMO D-SNP) Care Manager.	

	Covered Service	What you pay and any additional requirements
	Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (ten 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 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 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, 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 got 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 three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three 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.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Colorectal cancer screening *(continued)*	
	• 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.	
	Dental services This benefit includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. We pay for dental examinations, cleanings, fluoride treatment and any necessary x-rays. We pay for this service twice per rolling year. Examples of covered services include (but aren't limited to): • oral evaluations (examinations) • x-rays and other diagnostic imaging • dental cleaning (prophylaxis) • topical fluoride treatments • fillings • crowns • root canal therapy • scaling and root planing • complete and partial dentures • oral surgical procedures (to include extractions) • intravenous anesthesia/sedation (where medically necessary for oral surgical procedures) Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. **Some procedures may require prior authorization with documentation of medical necessity, including:** • Orthodontic services for members up to age 21 with adequate documentation of a handicapping malocclusion or medical necessity.	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Dental services *(continued)*	
	• Dental treatment in an operating room or ambulatory surgical center. We pay for some dental services when the 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.	
	Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0
	Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0
	Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ◦ a blood glucose monitor ◦ blood glucose test strips ◦ lancet devices and lancets	$0 **Important Blood Glucose Meter (BGM) Information:** We exclusively cover blood glucose meters (BGMs) and test strips manufactured and distributed by Accu-Chek/Roche and TRUE/ Trividia that are currently available. Meters and test strips produced by other manufacturers may be covered if medically necessary,
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Diabetic self-management training, services, and supplies *(continued)*	
	◦ glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: ◦ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ◦ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	such as large font or talking meters for the visually impaired. Medical exceptions for the visually impaired may be covered with an approved prior authorization. • Blood glucose meters (BGMs) 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 (BGMs), 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 *List of Covered Drugs*. • Prior authorizations 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. $0 **Important Continuous Glucose Monitor (CGM) Information:**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Diabetic self-management training, services, and supplies *(continued)*	
		• We cover all continuous glucose monitors (CGMs) at DME providers, but we exclusively cover Dexcom and Freestyle Libre at network pharmacies. • Prior authorization may be required for Dexcom and Freestyle Libre continuous glucose monitors (CGMs) at in-network pharmacies if insulin history within the past 6 months cannot be confirmed at the time of dispensing. • Prior authorization may be required for continuous glucose monitors (CGMs) and sensors at a DME provider, if exceeding quantity limits. • If exceeding quantity limits for monitors and sensors that align to Medicare coverage, guidance for prior authorizations is required. Exception requests may also be required. You can find participating network DME pharmacies and suppliers as well as providers for continuous glucose monitors (CGMs) on our website at: **AetnaMedicare.com/NJDSNP-find-provider** **Prior authorization may be required and is the responsibility of your provider.**
	Doula services We pay for the services of a doula. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Doula services *(continued)*	
	support for community-based resources. A doula doesn't replace a licensed medical professional and can't perform clinical tasks.	
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this *Evidence of Coverage* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or manufacturer, you may ask them if they can special-order it for you. Your provider must provide a prescription for covered DME and obtain prior authorization if required. Visit **AetnaMedicare.com/NJDSNP-find-provider** to find network DME providers.	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) For members under 21 years of age, we pay for the following services:	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) *(continued)*	
	• well child care • preventive screenings • medical examinations • vision and hearing screenings and services • immunizations • lead screening • private duty nursing services We pay for private duty nursing for eligible EPSDT members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.	

	Emergency care
	
	Emergency care means services that are:
	
	• given by a provider trained to give emergency services,
	• needed to evaluate or treat a medical emergency.
	
	A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	
	• serious risk to your life or to that of your unborn child; **or**
	• serious harm to bodily functions; **or**
	• loss of a limb or loss of function of a limb.
	• In the case of a pregnant woman in active labor, when:
	  ◦ There isn't enough time to safely transfer you to another hospital before delivery.
	  ◦ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	
	We also offer:
	
	• Emergency care (worldwide)
	• Emergency ambulance services (worldwide)
		$0
		
		If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan.

	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Emergency care *(continued)*	
	$250,000 annual maximum benefit for worldwide emergency, emergency ambulance, and urgently needed care. When getting emergency care or ambulance services outside the United States, 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.	
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Family planning services *(continued)*	
	Services furnished by out-of-network providers are paid for directly by Medicaid.	
	Fitness: Basic SilverSneakers® membership You are covered for a basic membership to any SilverSneakers® authorized participating fitness facility. Additionally, 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 SilverSneakers online enrichment classes to support your health and wellness, as well as your mental fitness. SilverSneakers health and wellness classes include, but are not limited to: cooking, food and nutrition, and mindfulness. SilverSneakers 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. 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 an authorized participating fitness facility. Information about authorized participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers. **Important:** You get a basic membership at any authorized participating SilverSneakers location. Facility amenities may vary by participating location including but not limited to hours, days and class types.	$0
	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-Hour Nurse Line. They can help with health-related questions when your doctor is not available. Call **1-844-362-0934** (**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.	$0

	Covered Service	What you pay and any additional requirements
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We pay for the following services: • routine hearing exams • diagnostic hearing exams and balance exams • otologic and hearing aid examinations prior to prescribing hearing aids • hearing aids, as well as associated accessories and supplies • exams for the purpose of fitting hearing aids • follow-up exams and adjustments • repairs after warranty expiration	$0
	HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services • physical therapy, occupational therapy, and speech therapy • medical and social services	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Home health agency care *(continued)*	
	• medical equipment and supplies	
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the 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 to treat symptoms and pain	$0 When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Aetna Medicare FIDE (HMO D-SNP). Hospice consultations are included as part of inpatient hospital care. Our plan covers all of your medical care not related to your terminal
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Hospice care *(continued)*	
	• short-term respite care • home care When you're admitted to a hospice, you have the right to stay in our plan. The plan also covers certain durable medical equipment, as well as spiritual and grief counseling. For members under 21 years of age, both palliative and curative care are covered. **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Evidence of Coverage*. **Note:** If you need non-hospice care, call your Care Manager and/or Member Services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Our plan covers all of your medical care not related to your terminal prognosis as it normally would. Our plan covers hospice consultation services (one time only)	prognosis as it normally would.
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Hospice care *(continued)*	
	for a terminally ill member who hasn't chosen the hospice benefit.	
	Housing Supports The Housing Supports program is a set of housing services intended to ensure that members can live in a safe, healthy, and affordable home. Housing Supports consists of four services: • Pre-tenancy Services (case management) • Tenancy Sustaining Services (case management) • Move-in Supports • Residential Modification and Remediation Services To be eligible for Housing Supports, a member must: • Meet at least one social-risk criterion (including, but not limited to: homelessness; at-risk of homelessness; transitioning from an institution; recently released from a correctional facility) • Meet at least one clinical-risk criterion (including, but not limited to: a chronic health condition; a mental health condition; substance misuse; pregnancy; complex medical health due to disability; sexual/domestic violence; assisted living needs; repeated hospitalization) Please contact your Care Manager or call the Member Services number at the bottom of this page for more information.	$0
	Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting hepatitis B • COVID-19 vaccines	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Immunizations *(continued)*	
	• other vaccines if you're at risk and they meet Medicare Part B coverage rules The full childhood immunization schedule is covered for members under the age of 21. We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Evidence of Coverage* to learn more.	
	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 you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • 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 • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse disorder treatment services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Inpatient hospital care *(continued)*	
	accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration • 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 from the Medicare fact sheet *Medicare Hospital Benefits* 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**.	
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. We pay for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. The plan covers the following services: • inpatient services in a psychiatric hospital • services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital • Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting)	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Kidney disease services and supplies We pay for the following services:	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Kidney disease services and supplies *(continued)*	
	• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Evidence of Coverage*, 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, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	
	Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least one pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0

	Covered Service	What you pay and any additional requirements
	Managed Long Term Services and Supports (MLTSS) The MLTSS program provides Home- and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. This MLTSS program is available to members who meet certain clinical and financial requirements. MLTSS services include (but aren't limited to): • assisted living services • cognitive, speech, occupational, and physical therapy • chore services • home-delivered meals • residential modifications (such as the installation of ramps or grab bars) • vehicle modifications • social adult day care • non-medical transportation	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Meal benefit (post-discharge) After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get 2 freshly prepared meals a day for 7 days. These meals are provided to help support your recovery or manage your health conditions. We have teamed up with our authorized vendor NationsMarket™ to provide this benefit. After we confirm your eligibility, NationsMarket will contact you to coordinate the delivery. **Note:** Observation and outpatient stays do not qualify you for this benefit. Meals must be scheduled for delivery within three months of the qualifying discharge as long as you are enrolled in the plan.	$0 Post-discharge meals must be provided through our authorized vendor NationsMarket. Meal delivery services through other vendors are not covered.
	Medical day care This benefit is for people with physical and/or cognitive impairments. Our plan pays for preventive, diagnostic, therapeutic and	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Medical day care *(continued)*	
	rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0
	Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0
	Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)	$0 Part B drugs may be subject to step therapy requirements. **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Medicare Part B drugs *(continued)*	
	• the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV). You may need additional scans and tests before and/or during treatment. Talk to your doctor about what scans and tests you may need as part of your treatment. • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • 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 covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • 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). 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 medication Sensipar	
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Medicare Part B drugs *(continued)*	
	• 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 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-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link takes you to a list of Medicare Part B drugs that may be subject to Step Therapy: **AetnaMedicare.com/NJDSNP-drug-formulary**. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Evidence of Coverage* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Evidence of Coverage* gives more information about the *Explanation of Benefits (EOB)* and how it helps you track your drug coverage.	
	Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Nursing facility care *(continued)*	
	• drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
	Nutrition Supports Program The nutrition supports program is intended to help members in MLTSS assess their dietary needs and nutritional options, and also includes services to provide pantry items and/or groceries to members under certain circumstances to ensure they have adequate access to food. The plan will conduct an assessment to determine eligibility for the benefit.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Nutrition Supports Program *(continued)*	
	Nutrition Counseling and Education: Nutrition counseling and education assesses a member's dietary intake, identifies areas where changes are needed, and provides individualized advice and guidance about options and methods for improving nutritional status. Strategies can be provided in individual or group settings and are meant to motivate and facilitate food choices, meal preparation, and other food and nutrition-related behaviors conducive to health and wellbeing. To be eligible for nutrition counseling and education, a member must be enrolled in MLTSS and experiencing a significant or emergent disruption in their ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement. **Transitional Pantry Stocking** The one-time purchase of essential pantry stocking items to ensure adequate and necessary access to food and goods immediately following transition from an institutional setting. This may include various foods, ingredients, baking supplies, and certain household items. To be eligible for transitional pantry stocking, a member must be enrolled in MLTSS and meet the following risk factors: • Meet the USDA definition of either low or very low food security; • Transitioning to a community residence from an institutional setting, such as a certified nursing home, mental health facility, acute care hospital with an extended stay (30 days or more); carceral settings (for example, state prison, county correctional facility); and • Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence. **Short-Term Grocery Provision:** The provision of short-term groceries purchased and delivered from a food retailer, for an MLTSS beneficiary who meets eligibility requirements.	
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Nutrition Supports Program *(continued)*	
	To be eligible for Short-Term Grocery Provision, a member must be enrolled in MLTSS and: • Meet the USDA definition of either low or very low food security; • Be experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement. Please contact your Care Manager or call the Member Services number at the bottom of this page for more information.	
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here:	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Outpatient diagnostic tests and therapeutic services and supplies *(continued)*	
	• X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • 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 condition • other outpatient diagnostic tests	
	Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services 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 law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. 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 hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf.**	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Outpatient hospital services *(continued)*	
	• services in an emergency department or outpatient clinic, such as outpatient surgery or observation services • labs 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 needed without it • X-rays and other radiology services billed by the hospital • medical supplies, such as splints and casts • some drugs and biologicals that you can't give yourself	
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker (CSW) • a clinical nurse specialist (CNS) • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws • an Independent Practitioner Network or IPN (psychiatrist, psychologist, or Advanced Practice Nurse (APN)) Additionally, the plan covers the following services: • adult mental health rehabilitation (supervised group homes and apartments) • mental health outpatient (clinic/hospital services) • partial care and medication management	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Outpatient rehabilitation services *(continued)*	
	You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	
	Outpatient substance use disorder treatment services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment The plan covers substance use disorder screening, referrals, drugs, and treatment of conditions. Covered services include, but aren't limited to, the following: • non-medical detoxification/non-hospital based withdrawal management • substance use disorder short term residential • ambulatory withdrawal management with extended on-site monitoring/ambulatory detoxification • substance use disorder partial care • substance use disorder intensive outpatient • substance use disorder outpatient • opioid treatment services (methadone and non-methadone medication assisted treatment) • Refer to "Opioid treatment program (OTP) services" earlier in this chart for details. • Peer Recovery Support Services (PRSS)	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Outpatient surgery We pay for outpatient surgery and services 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	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

Covered Service	What you pay and any additional requirements
Outpatient surgery *(continued)*	
or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	

Over-the-Counter (OTC) Wallet
You get an Over-the-Counter (OTC) Wallet with a $260 monthly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card to help pay for:
• 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.
• Approved OTC products can be purchased:
  • In-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores)
  • Using the CVS Flex Benefits™ app. The app can also be used to locate authorized participating retail stores and identify covered products.
  • Online at **CVS.com/Aetna**
  • By phone through CVS Flex Benefits at **1-844-428-8147** (**TTY: 711**)
• Some products available online or in-store may occasionally be out of stock. If your benefit expiration date is approaching, be sure to use your funds. Unused balances will not roll over. Plan your allowance carefully, as exceptions will not be granted once the benefit period has ended.
 	
Your monthly benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each month. Be sure to use the full benefit amount each month, because any unused benefit amount will not roll over into the next month nor will it roll over into the next plan year. No exceptions will be made to add additional or unused funds 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 total cost of your purchase including taxes, it will be your responsibility to cover the difference with another form of payment. For more information on the Aetna Medicare Extra Benefits Card, see the **Aetna Medicare Extra Benefits Card** section in Chapter 4.
	$0
	
	The OTC Wallet can only be used to purchase approved OTC products at authorized participating retail locations and online or on the app, or by phone through our authorized vendor CVS Flex Benefits™.

	Covered Service	What you pay and any additional requirements
	Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, 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 or therapist's office but less intense than partial hospitalization.	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Personal Care Assistance (PCA) Covers health related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care.	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Personal emergency response system We cover a personal emergency response system through our authorized vendor LifeStation to provide you with access to help in the event of an emergency, 24 hours a day, 7 days a week. This benefit includes the equipment (in-home, mobile with GPS, or smartwatch), shipping, fulfillment, monitoring and customer service. Optional fall detection and a lockbox for easier emergency entry are also available. Call your Care Manager to learn more. Or call Member Services at the number at the bottom of the page for assistance.	$0 for the personal emergency response system through our authorized vendor LifeStation. Members access this benefit through Aetna care management.
	Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: ◦ physician's office ◦ certified ambulatory surgical center ◦ hospital outpatient department ◦ any other location	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Physician/provider services, including doctor's office visits *(continued)*	
	• consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need 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 abuse services (individual sessions) ◦ Outpatient substance abuse 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**. ◦ 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/**	
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Physician/provider services, including doctor's office visits *(continued)*	
	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 members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of your location • telehealth services for diagnosis, evaluation, and treatment of mental health disorders • 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 five to ten minutes • evaluation of video and/or images you send to your doctor, interpretation, and follow-up by your doctor within 24 hours • consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • second opinion by another network provider before surgery	
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • routine exams	$0

	Covered Service	What you pay and any additional requirements
	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 including the fee for injecting the drug, if applicable. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. • A one-time hepatitis B virus screening	$0
	Private Duty Nursing (PDN) This benefit is for eligible members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. It's covered for MLTSS members of any age.	$0 **Prior authorization may be required and is the responsibility of your provider.**
	Prostate cancer screening exams For men age 50 and over (and for men 40 and older with a family history of prostate cancer or other risk factors), we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
	Prosthetic and orthotic devices and related supplies Prosthetic devices 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 • colostomy bags and supplies related to colostomy care • pacemakers • braces	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Prosthetic and orthotic devices and related supplies *(continued)*	
	• prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0
	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.	$0
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Sexually transmitted infections (STIs) screening and counseling *(continued)*	
	tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	
	Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12**. Unlimited days based on medical necessity. No prior hospital stay is required. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services • long-term (custodial) care in a nursing facility You usually get SNF care from network facilities. Under certain conditions, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:	$0 **Prior authorization may be required and is the responsibility of your provider.**
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Skilled nursing facility (SNF) care *(continued)*	
	• a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	
	Smoking and tobacco use cessation Counseling to quit smoking and tobacco use is covered on an outpatient and hospitalized basis for people 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 two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year). The plan also covers over-the-counter (OTC) smoking cessation products, including nicotine gums, nicotine lozenges and nicotine patches.	$0
	Special Supplemental Benefits for the Chronically Ill **Special Supplemental Benefits** Our plan offers additional benefits to members with a qualifying chronic condition who meet all other criteria. The information below describes eligibility criteria and the process for verifying eligibility. **Eligibility requirements:** If you are diagnosed with one or more of the chronic conditions listed below and meet all other criteria, you may be eligible for additional benefits under our plan to help manage your overall health and wellness. 1. You must be diagnosed with one or more of the qualifying chronic conditions listed below.‡	$0 The Extra Supports Wallet can only be used at authorized participating retail stores and online or by phone through CVS Flex Benefits™.
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	2. You have a high risk of hospitalization or other adverse health outcomes. 3. You require intensive care coordination. ‡Qualifying chronic conditions: • Anemia • Autoimmune disorders limited to: ◦ Dermatomyositis ◦ Polyarteritis nodosa ◦ Polymyalgia rheumatica ◦ Polymyositis ◦ Psoriasis ◦ 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	
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	• 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	
	This benefit is continued on the next page.	

Covered Service	What you pay and any additional requirements
Special Supplemental Benefits for the Chronically Ill *(continued)*	
◦ 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 Eligibility will be determined based on your medical and pharmacy claims, and other clinical information. This information must support a reasonable expectation that the	
This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	benefit will help maintain or improve your health or overall function. You can also have your provider submit a signed provider attestation form that confirms you meet all the eligibility requirements. If you need a provider attestation form, call the Member Services number at the bottom of this page. Enrollment in the plan does not guarantee eligibility. You will receive Special Supplemental Benefits after it is determined that you meet the eligibility requirements listed above. However, you will not receive benefits for any time period before your eligibility was determined. If you have questions about the eligibility requirements to receive this benefit, visit **aet.na/NJQualify**. You can also contact your Care Manager at **1-844-362-0934** (**TTY: 711**) 8 AM - 5 PM, Monday through Friday and they will work with you to determine your eligibility. **Benefit:** **Extra Supports Wallet** If you qualify, the $260 monthly benefit amount in the Over-the-Counter (OTC) Wallet will change to the Extra Supports Wallet with additional spending categories. Qualified members can use this wallet to help pay for: • Healthy foods including meat, produce, dairy products, and more. ◦ Approved healthy foods can be purchased in-store at authorized participating retail stores and online at **CVS.com/Aetna**, by using the CVS Flex Benefits™ app, and 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.	
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	◦ Approved OTC products can be purchased in-store at authorized participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at **CVS.com/Aetna**, by using the CVS Flex Benefits app and 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, such as Uber and Lyft, 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® and be a recognized utility service provider. Utility expenses must be paid directly to the provider using the card. **Note:** Not all utility providers accept the Extra Benefits Card. • Personal care products including paper towels, shampoo, soap, and more. ◦ Approved personal care products can be purchased in-store at authorized participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at **CVS.com/Aetna**, by using the CVS Flex Benefits app and by phone at **1-844-428-8147** (**TTY: 711**). Your eligibility for this wallet must be determined by the 15th day of the month in order to receive the benefit amount for that month. If eligibility is determined after the 15th day of the month, the benefit amount will be available the following month. Going forward, for each month you are eligible, the benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each month.	
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	Be sure to use the full benefit amount each month, because any unused benefit amount will not roll over into the next month nor will it roll over into the next plan year. No exceptions will be made to add additional or unused funds 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 total cost of your purchase including taxes, it will be your responsibility to cover the difference with another form of payment. For more information on the Aetna Medicare Extra Benefits Card, see the **Aetna Medicare Extra Benefits Card** section in Chapter 4.	
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) trained in both basic and advanced life support techniques	$0
	Transportation Medicaid Fee-for-Service directly covers non-emergency transportation.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay and any additional requirements
	Transportation *(continued)*	
	Covered services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). All non-emergency transportation is arranged through the state's transportation vendor, Modivcare. To schedule transportation, call Modivcare at **1-866-527-9933**. You can also ask your PCP or Care Manager to help you to arrange this service. Please call your Care Manager and/or Member Services for more information at **1-844-362-0934**. (TTY users should call **711**). Hours of operation are 8 AM to 8 PM, 7 days a week.	
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it's not possible, or it's unreasonable, to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). We also offer: • Urgent care (worldwide) $250,000 annual maximum benefit for worldwide emergency care, emergency ambulance, and urgently needed care. When getting emergency care or ambulance services outside the United States, 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.	$0

	Covered Service	What you pay and any additional requirements

	Vision care
	We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye, including a comprehensive eye exam once per year for all members. For example, treatment for age-related macular degeneration.
	
	For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:
	• people with a family history of glaucoma
	• people with diabetes
	• African-Americans who are 50 and over
	• Hispanic Americans who are 65 and over
	
	For people with diabetes, we pay for screening for diabetic retinopathy once per year.
	
	For all other members aged 35 and over, a glaucoma screening is covered every five years.
	
	We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.
	
	If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.
	
	The plan also covers the following:
	• optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses
	• replacement lenses and frames (or contact lenses)
	  • once every 24 months for people age 19 through 59, **or**
	  • once per year for beneficiaries 18 years of age or younger, **or**
	  • once per year for beneficiaries 60 years of age or older
		$0

	Covered Service	What you pay and any additional requirements
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots (or vaccines)), **and** • referrals for other care if you need it **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0
	Wigs for hair loss related to chemotherapy You get a $400 benefit amount (allowance) every year for covered wigs needed for hair loss as a result of chemotherapy. For assistance in purchasing a wig, please call Member Services at **1-844-362-0934** (**TTY: 711**), 8 AM to 8 PM, 7 days a week.	$0

E. Benefits covered outside of our plan

We don't cover the following services, but they're available through NJ FamilyCare.

- Non-emergency transportation, including mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and delivery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). These services are paid for directly by Medicaid (also known as Medicaid Fee-for-Service).

F. Benefits not covered by our plan, Medicare, or NJ FamilyCare

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medicaid don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and medically necessary," according to Medicare and NJ FamilyCare standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines and as described in Chiropractic services in the Benefits Chart in **Section D**
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy and LASIK surgery
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities.

Chapter 5: Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and NJ FamilyCare. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5**, **Section F3** "In a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider that is providing care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription. (Refer to **Section A** for more information.) Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs.* We call it the "*Drug List*" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug. A **medically accepted indication** is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Your drug may require approval from our plan based on certain criteria before we'll cover it. Refer to **Section C** in this chapter.

Table of Contents

Chapter 5 Getting your outpatient drugs

A. Getting your prescriptions filled 99

A1. Filling your prescription at a network pharmacy 99

A2. Using your Member ID Card when you fill a prescription 99

A3. What to do if you change your network pharmacy 99

A4. What to do if your pharmacy leaves the network 99

A5. Using a specialized pharmacy 99

A6. Using mail–order services to get your drugs 100

A7. Getting a long–term supply of drugs 101

A8. Using a pharmacy not in our plan's network 102

A9. Paying you back for a prescription 102

B. Our plan's Drug List 102

B1. Drugs on our *Drug List* 102

B2. How to find a drug on our *Drug List* 103

B3. Drugs not on our *Drug List* 103

C. Limits on some drugs 104

D. Reasons your drug might not be covered 105

D1. Getting a temporary supply 105

D2. Asking for a temporary supply 106

D3. Asking for an exception 107

E. Coverage changes for your drugs 107

F. Drug coverage in special cases 109

F1. In a hospital or a skilled nursing facility for a stay that our plan covers 109

F2. In a long–term care facility 109

F3. In a Medicare–certified hospice program 109

G. Programs on drug safety and managing drugs 110

G1. Programs to help you use drugs safely 110

G2. Programs to help you manage your drugs 110

G3. Drug management program for safe use of opioid medications 111

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory,* visit our website, or contact Member Services.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered drug, or you can ask the pharmacy to look up your plan enrollment information.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary 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. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Evidence of Coverage.*
- If you need help getting a prescription filled, contact Member Services.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory,* visit our website, or contact Member Services.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.) To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory,* visit our website, or contact Member Services.

A6. Using mail–order services to get your drugs

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

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

Filling prescriptions by mail
To get order forms and information about filling your prescriptions by mail, visit our website (**AetnaMedicare.com/NJDSNP**) or contact Member Services.

Usually, a mail-order prescription arrives within 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.

Mail-order processes
Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care

providers. You may 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 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 contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Member Services.

3. 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 contacts 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, contact your pharmacy 15 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by logging on to your **Caremark.com** account or by calling Member Services.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Provide the pharmacy with your current mailing address, email address and/or phone number(s) and any special mailing instructions you may require.

A7. Getting a long–term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- 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 service 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.

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.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of this *Evidence of Coverage*.

B. Our plan's *Drug List*

We have a *List of Covered Drugs*. We call it the "*Drug List*" for short.

We select the drugs on the *Drug List* with the help of a team of doctors and pharmacists. The *Drug List* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *Drug List* when you follow the rules we explain in this chapter.

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under NJ FamilyCare.

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

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

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products 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.

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

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our *Drug List*

To find out if a drug you take is on our *Drug List*, you can:

- Visit our plan's website at **AetnaMedicare.com/NJDSNP-drug-formulary**. The *Drug List* on our website is always the most current one.
- Call Member Services to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at **Caremark.com** to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call Member Services.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List*. For more information refer to **Chapter 9**.

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Evidence of Coverage* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and NJ FamilyCare drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use."

Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or NJ FamilyCare can't cover the types of drugs listed below.

- 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 the treatment of anorexia, weight loss, or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

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 provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Evidence of Coverage*.

1. Limiting use of a brand name drug or original biological products when respectively, a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you respectively, the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. 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 approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at **AetnaMedicare.com/NJDSNP-drug-formulary** for more information about prior authorization.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at **AetnaMedicare.com/NJDSNP-drug-formulary** for more information about step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Member Services or check our website at **AetnaMedicare.com/NJDSNP-drug-formulary**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Evidence of Coverage*.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:

- is no longer on our *Drug List* **or**
- was never on our *Drug List* **or**
- is now limited in some way.

2. You must be in one of these situations:

- You were in our plan last year.
  - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You're new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - If you experience a change in your setting of care (such as being discharged or admitted to a long-term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with a temporary supply (at least a 31-day supply) for applicable drug(s).

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our *Drug List* or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception 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.

To learn more about asking for an exception, refer to **Chapter 9** of this *Evidence of Coverage*.

If you need help asking for an exception, contact Member Services.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior authorization for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another 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*. For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?
To get more information on what happens when our *Drug List* changes, you can always:

- Check our current *Drug List* online at **AetnaMedicare.com/NJDSNP-drug-formulary** **or**
- Call Member Services at the number at the bottom of the page to check our current *Drug List.*

Changes we may make to the *Drug List* that affect you during the current plan year
Some changes to the *Drug List* will happen immediately. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug. If you're taking a drug, you'll likely hear about any changes after they're made.
  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.
  - We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of this *Evidence of Coverage* for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. Your prescriber will also know about this change, and can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our *Drug List* **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Evidence of Coverage*.

Changes to the *Drug List* that don't affect you during this plan year
We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year.**

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you above these types of changes directly during the current 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 that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long–term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it's not or if you need more information, contact Member Services.

F3. In a Medicare–certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it's not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Evidence of Coverage* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Member Services.

G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. 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 isn't safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from certain pharmacies and/or from certain prescribers
- Limiting the amount of those medications we'll cover for you

If we think that one or more limitations should apply to you, we 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 provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you're at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we'll review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Evidence of Coverage*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and NJ FamilyCare (Medicaid) drugs

Introduction

This chapter tells what you pay for your outpatient drugs. By “drugs,” we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under NJ FamilyCare (Medicaid).

Because you’re eligible for NJ FamilyCare, you get "Extra Help" from Medicare to help pay for your Medicare Part D drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

To learn more about drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the *Drug List*. It tells you:
    - which drugs we pay for
    - if there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at **AetnaMedicare.com/NJDSNP-drug-formulary**.
- **Chapter 5** of this *Evidence of Coverage*.
  - It tells how to get your outpatient drugs through our plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn’t cover.
  - When you use the plan’s “Real Time Benefit Tool” to look up drug coverage (refer to **Chapter 5**, **Section B2**), the cost shown is an estimate of the out-of-pocket costs you’re expected to pay. You can call your Care Manager or Member Services for more information.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Evidence of Coverage* for more information about network pharmacies.

Table of Contents

Chapter 6 What you pay for your Medicare and NJ FamilyCare (Medicaid) drugs

A. The Explanation of Benefits (EOB) **114**

B. How to keep track of your drug costs **114**

B1. What if you find mistakes on this summary? **115**

B2. What about possible fraud? **115**

C. You pay nothing for a one-month or long-term supply of drugs **115**

C1. Getting a long-term supply of a drug **116**

D. What you pay for Part D vaccines **116**

D1. What you need to know before you get a vaccine **116**

D2. What you pay for a vaccine covered by Medicare Part D **116**

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you got a covered Part D drug, 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, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs.** This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits.* We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what others paid for you.
- **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 is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.

We offer coverage of drugs not covered under Medicare.

- To find out which drugs our plan covers, refer to our *Drug List*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under NJ FamilyCare. These drugs are included in the *Drug List*.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

Here are examples of when you should give us copies of your receipts:
- When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit.
- When you pay a copay for drugs that you get under a drug maker's patient assistance program.
- When you buy covered drugs at an out-of-network pharmacy.
- When you pay the full price for a covered drug under special circumstances.

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this *Evidence of Coverage*.

3. **Send us information about 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 most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

   When you get an EOB in the mail, make sure it's complete and correct.
   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

B1. What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Aetna Medicare FIDE (HMO D-SNP) Member Services. You can also find answers to many questions on our website: **AetnaMedicare.com/NJDSNP**.

B2. What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Aetna Medicare FIDE (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call these numbers for free.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They're an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs if you follow our rules. Refer to **Chapter 9** of this *Evidence of Coverage* to learn about how to file an appeal if you're told a drug won't be covered. To learn

more about these pharmacy choices, refer to **Chapter 5** of this *Evidence of Coverage* and our *Provider and Pharmacy Directory.*

C1. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There's no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Evidence of Coverage* or our *Provider and Pharmacy Directory.*

D. 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 Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List.* Our plan covers adult Medicare Part D vaccines at no cost to you.

D1. What you need to know before you get a vaccine

We recommend that you call Member Services if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine.

D2. What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage.*
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. If the vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you'll pay nothing.
   - For other Part D vaccines, you pay nothing for the vaccine.

2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you have

to pay nothing for the vaccine.

3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay nothing for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage.*

Table of Contents

Chapter 7 Asking us to pay a bill you got for covered services or drugs

A. Asking us to pay for your services or drugs **119**

B. Sending us a request for payment **121**

C. Coverage decisions **121**

D. Appeals **122**

A. Asking us to pay for your services or drugs

You shouldn't get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow Aetna Medicare FIDE (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Section B.**

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
- If we don't cover the services or drugs, we'll tell you.

Contact Member Services if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we'll pay the provider directly.
  - If you already paid for the Medicare service, we'll pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services. **Call Member Services** at the number at the bottom of this page **if you get any bills**.

- Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of this *Evidence of Coverage* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.
- 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 prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (*Drug List*) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Evidence of Coverage*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Evidence of Coverage*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Evidence of Coverage*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services or call us. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records**. You must send your information to us within **12 months** of the date you received the service, item, or Part B drug.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- Call Member Services at **1-844-362-0934** (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 receipts to this address:

Aetna Medicare FIDE (HMO D-SNP)
Aetna Duals COE Member Correspondence
PO Box 982980
El Paso, TX 79998

For Part D and Medicaid prescription drug claims (including vaccines for preventing shingles or chicken pox): Mail your request for payment together with any bills or paid receipts to this address:

Aetna Medicare FIDE (HMO D-SNP)
Aetna Integrated Pharmacy Solutions
PO Box 52446
Phoenix, AZ 85072

You must submit your claim to us within **36 months** of the date you got the Part D drug.

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay for it. If you already paid for the service or drug, we'll mail you a check for what you paid. If you paid the full cost of a drug, you might not be reimbursed 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 is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this *Evidence of Coverage* explains the rules for getting your services covered. **Chapter 5** of this *Evidence of Coverage* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9.**

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal."

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Evidence of Coverage*:

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage.*

Table of Contents

Chapter 8 Your rights and responsibilities

A. Your right to get services and information in a way that meets your needs **124**

B. Our responsibility for your timely access to covered services and drugs **125**

C. Our responsibility to protect your personal health information (PHI) **126**

- **C1. How we protect your PHI** **126**
- **C2. Your right to look at your medical records** **126**

D. Our responsibility to give you information **127**

E. Inability of network providers to bill you directly **128**

F. Your right to leave our plan **128**

G. Your right to make decisions about your health care **128**

- **G1. Your right to know your treatment choices and make decisions** **128**
- **G2. Your right to say what you want to happen if you can't make health care decisions for yourself** **129**
- **G3. What to do if your instructions aren't followed** **129**

H. Your right to make complaints and ask us to reconsider our decisions **130**

- **H1. What to do about unfair treatment or to get more information about your rights** **130**

I. Your responsibilities as a plan member **130**

J. Other rights and responsibilities under NJ FamilyCare **131**

- **J1. Member responsibilities** **131**
- **J2. Member rights** **131**
- **J3. MLTSS member responsibilities** **132**
- **J4. MLTSS member rights** **133**

A. Your right to get services and information in a way that meets your needs

You have the right to be treated with respect and recognition of your dignity, including respect for your privacy.

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner, including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Member Services at **1-844-362-0934** (**TTY: 711**). Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English, including Spanish, and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services at **1-844-362-0934** (**TTY: 711**) or write to:
  Aetna Duals COE Member Correspondence PO Box 982980
  El Paso, TX 79998

This document is available for free in Spanish.

Aetna Medicare FIDE (HMO D-SNP) wants to make sure you understand your health plan information.

- If a different language or format works better for you, call Member Services at the number listed at the bottom of this page to request a change. (This is called a "standing request.")
- We will continue sending you mailings and other communications in your requested format.
- If you want to change your standing request for a preferred language or format, call Member Services.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**.
- NJ Department of Human Services, Division of Medical Assistance & Health Services at **1-800-701-0710**. TTY users should call **711**
- Office for Civil Rights at **1-800-368-1019**. TTY users should call **1-800-537-7697**.

A. Su derecho a obtener servicios e información de una manera que cumpla con sus necesidades

Usted tiene derecho a ser tratado con respeto y a que se reconozca su dignidad, incluido el respeto a su privacidad.

Debemos asegurarnos de que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y accesible, incluso para aquellas personas con un dominio limitado del inglés, habilidades de lectura limitadas, una discapacidad auditiva o diversos antecedentes culturales y étnicos. También debemos informarle sobre los beneficios del plan y sus derechos de una manera que

usted pueda comprender. Debemos informarle sobre sus derechos cada año que se encuentre en nuestro plan.

- Para obtener información de una manera que pueda comprender, llame a Servicios para Miembros al **1-844-362-0934** (**TTY: 711**). Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder preguntas en distintos idiomas.
- Nuestro plan también puede proporcionarle materiales en otros idiomas además del inglés, incluido el español, y en formatos diferentes, como tamaño de letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para Miembros al **1-844-362-0934** (**TTY: 711**), o escriba a:
  Aetna Duals COE Member Correspondence PO Box 982980
  El Paso, TX 79998

Este documento está disponible sin cargo en español.

Aetna Medicare FIDE (HMO D-SNP) quiere asegurarse de que usted comprenda la información de su plan de salud.

- Si un idioma o formato diferente funciona mejor para usted, llame a Servicios para Miembros al número que aparece al final de esta página para solicitar el cambio. (Esto se denomina “solicitud permanente”).
- Continuaremos enviando correspondencias y otras comunicaciones en su formato solicitado.
- Si quiere cambiar su solicitud permanente de un idioma o formato preferido, llame a Servicios para Miembros.

Si tiene dificultad para obtener información de nuestro plan debido a problemas relacionados con el idioma o una discapacidad, y desea presentar un reclamo, llame a:

- Medicare al 1-800-MEDICARE (**1-800-633-4227**). Los usuarios de TTY deben llamar al **1-877-486-2048**.
- Departamento de Servicios Humanos de New Jersey, División de Asistencia Médica y Servicios de Salud, al **1-800-701-0710**. Los usuarios de TTY deben llamar al **711**.
- Oficina de Derechos Civiles al **1-800-368-1019**. Los usuarios de TTY deben llamar al **1-800-537-7697**.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Evidence of Coverage.*
  - Call Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- We **don’t** require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.

  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior authorization (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Evidence of Coverage*.

Chapter 9 of this *Evidence of Coverage* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't

routine.

If you have questions or concerns about the privacy of your PHI, call Member Services.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. Many documents are also available in Spanish. We can also give you information in large print, braille, or audio, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this *Evidence of Coverage*) and drugs (refer to **Chapters 5 and 6** of this *Evidence of Coverage*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Evidence of Coverage*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got
- New medical treatments: We are always considering new medical treatments. We want you to get safe, up-to-date, and high-quality medical care. A team of providers reviews new health care methods. They decide if they should become covered services. Services and treatments that are being researched and studied are not covered services. We take these steps to decide if new treatments will be a covered benefit or service:
  - Study the purpose of each new treatment

- Review medical studies and reports
- Determine the impact of a new treatment
- Develop guidelines on how and when to use the new treatment

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Evidence of Coverage.*

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Evidence of Coverage*:
  - For more information about when you can join a new MA or drug benefit plan.
  - For information about how you'll get your NJ FamilyCare benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.

- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Evidence of Coverage* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people can't make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever can't make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you can't make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to 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're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact the SHIP program at **1-800-792-8820** (TTY: **711**). For more details about New Jersey State Health Insurance Assistance Program (SHIP), refer to Chapter 2.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Evidence of Coverage* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

You also have the right to make recommendations regarding our plan's policies related to member rights and responsibilities.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Evidence of Coverage* – or you want more information about your rights, you can call:

- Member Services
- The SHIP program at **1-800-792-8820** (**TTY: 711**). For more details about the SHIP, refer to **Chapter 2, Section C**.
- The Ombudsperson Program at **1-800-446-7467**, **609-292-7272**. For more details about this program, refer to **Chapter 2** of this *Evidence of Coverage*.

Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf**).

You can also contact the New Jersey Medicaid program for assistance. You can call the NJ Department of Human Services, Division of Medical Assistance and Health Services at **1-800-701-0710** (TTY: **711**).

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read this *Evidence of Coverage*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this *Evidence of Coverage*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this *Evidence of Coverage.*
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.

- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Evidence of Coverage* tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and NJ FamilyCare your new address when you move. Refer to **Chapter 2** of this *Evidence of Coverage* for phone numbers for Medicare and NJ FamilyCare.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call Member Services for help if you have questions or concerns.**

J. Other rights and responsibilities under NJ FamilyCare

J1. Member responsibilities

You must:

- Provide, as much as possible, the information the professional staff needs to care for you
- Follow the instructions and guidelines given by your health care providers

J2. Member rights

You have the right:

- To be treated with respect, dignity, and need for privacy
- To be given information about the organization, its services, the practitioners providing care, and your rights and responsibilities
- To be able to communicate and be understood, with the help of a translator if you need one

- To choose your primary care practitioners (within the plan network) and the right to refuse care from specific practitioners
- To participate in making decisions about your health care
- To be fully informed by the Primary Care Practitioner, other health care provider, or Care Manager about your health and functional status, and to participate in developing a plan of care that promotes your functional abilities and encourages independence
- To voice any complaints about the organization or the care you get and to recommend changes in policies and services to plan staff, providers, and outside representatives of your choice. You have the right to do this free of restraint, interference, coercion, discrimination, or reprisal by the plan or its providers
- To prepare advance directives
- To access your medical records, following applicable Federal and State laws
- To be free from harm, including unnecessary physical restraints or isolation, too much medication, physical or mental abuse, or neglect
- To be free of hazardous procedures
- To receive information on available treatment options or alternative courses of care
- To refuse treatment and to be informed of the consequences of such refusal
- To have services provided that promote
  - a meaningful quality of life
  - independence
  - independent living in your home or another community setting as long as it is medically and socially possible
  - your natural support systems
- To choose or refuse health care in lieu of services or settings that the plan must provide, as long as the choices are medically appropriate and cost-effective.

J3. MLTSS member responsibilities

You must:

- Provide, as much as you can, the information needed by the professional staff that cares for you
- Follow the instructions and guidelines given by your health care providers
- Give all health and treatment-related information — including your medications, circumstances, living arrangements, and your support systems — to your Care Manager to identify your care needs and develop a plan of care
- Understand your health care needs and work with your Care Manager to set or change your goals and services and to create or modify your plan of care so you can get the services you need in a timely way
- Ask questions when you don't understand something
- Understand the risks associated with your decisions about care
- Tell your Care Manager about any significant changes to your health condition, medications, circumstances, living arrangements, or support systems
- Tell your Care Manager if any problems occur or if you are unhappy with the services you are getting
- Follow your health plan's rules and the rules of institutional or residential settings

J4. MLTSS member rights

You have the right:

- To request and receive information on the services available to you
- To have access to qualified service providers and the ability to choose between them
- To be informed of your rights before you get approved services that you have chosen
- To receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability
- As a resident of an MLTSS community, you have the right to:
  - have a key to lock/unlock the home and bedroom doors
  - have visitors of your choosing
  - make and receive phone calls
  - make an independent schedule
  - have access to food at any time unless otherwise determined in a documented, person-centered process
  - have access to appropriate services that support your health and welfare
- To assume risk after being fully informed and able to understand the risks and results of the decisions made
- To make decisions about your care needs
- Participate in developing your plan of care and making changes to it
- Request service changes at any time, including adding, increasing, decreasing, or discontinuing
- Request and receive from your Care Manager a list of names and duties of any person(s) who provides services to you under the plan of care
- Receive support and direction from your Care Manager to resolve concerns about your care needs or complaints about services or providers
- Be informed of and receive in writing facility-specific resident rights when you are admitted to an institutional or residential setting
- Be informed of all the covered/required services you are entitled to, required by or offered by the institutional or residential setting, and any facility charges not covered by the managed care plan
- Not be transferred or discharged out of a facility except:
  - for medical necessity
  - to protect your physical welfare and safety or the welfare and safety of other residents
  - because of failure, after reasonable and appropriate notice, of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment
- Have your health plan protect and promote your ability to exercise all rights identified in this document
- Have all the rights and responsibilities outlined here sent to your authorized representative or court-appointed legal guardian

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about our plan.
- You need a service, item, or medication that our plan said it won't pay for.
- You disagree with a decision our plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation**.

Table of Contents

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

A. What to do if you have a problem or concern **136**
- **A1. About the legal terms** **136**

B. Where to get help **136**
- **B1. For more information and help** **136**

C. Understanding Medicare and NJ FamilyCare complaints and appeals in our plan **137**

D. Problems with your benefits **137**

E. Coverage decisions and appeals **137**
- **E1. Coverage decisions** **138**
- **E2. Appeals** **138**
- **E3. Help with coverage decisions and appeals** **138**
- **E4. Which section of this chapter can help you** **139**

F. Medical care **139**
- **F1. Using this section** **139**
- **F2. Asking for a coverage decision** **140**
- **F3. Making a Level 1 Appeal** **142**
- **F4. Making a Level 2 Appeal** **144**
- **F5. Payment problems** **148**

G. Medicare Part D drugs **149**
- **G1. Medicare Part D coverage decisions and appeals** **149**
- **G2. Medicare Part D exceptions** **150**

G3. Important things to know about asking for an exception 151
G4. Asking for a coverage decision, including an exception 151
G5. Making a Level 1 Appeal 153
G6. Making a Level 2 Appeal 154
H. Asking us to cover a longer hospital stay 156
H1. Learning about your Medicare rights 156
H2. Making a Level 1 Appeal 157
H3. Making a Level 2 Appeal 158
I. Asking us to continue covering certain medical services 159
I1. Advance notice before your coverage ends 159
I2. Making a Level 1 Appeal 159
I3. Making a Level 2 Appeal 160
J. Taking your appeal beyond Level 2 161
J1. Next steps for Medicare services and items 161
J2. Additional NJ FamilyCare appeals 162
J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests 162
K. How to make a complaint 163
K1. What kinds of problems should be complaints 163
K2. Internal complaints 165
K3. External complaints 166

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- "Making a complaint" instead of "filing a grievance"
- "Coverage decision" instead of "organization determination," "benefit determination," "at-risk determination," or "coverage determination"
- "Fast coverage decision" instead of "expedited determination"
- "Independent Review Organization" (IRO) instead of "Independent Review Entity" (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from our plan
You can call our plan at 1-844-362-0934 (TTY: 711) to help deal with a problem or answer questions.

Help from the State Health Insurance Assistance Program (SHIP)

You can call the SHIP 1-800-792-8820 (**TTY:** 711). You can also review their website at nj.gov/humanservices/doas/services/q-z/ship/. The SHIP counselors can answer your questions and help you understand what to do about your problem. The SHIP isn't connected with us or with any insurance company or health plan. The SHIP has trained counselors in every county, and services are free. The SHIP phone number is 1-800-792-8820 (**TTY:** 711).

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

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

Help and information from the NJ Department of Human Services, Division of Medical Assistance and Health Services (the New Jersey Medicaid program)

You can get help and information from the Division of Medical Assistance & Health Services (the New Jersey Medicaid program) by calling **1-800-701-0710** (**TTY: 711**). Their website can be found at **state.nj.us/humanservices/dmahs/**.

C. Understanding Medicare and NJ FamilyCare complaints and appeals in our plan

You have Medicare and NJ FamilyCare. Information in this chapter applies to **all** your Medicare and NJ FamilyCare benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and NJ FamilyCare processes.

Sometimes Medicare and NJ FamilyCare processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a NJ FamilyCare benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E**, "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals 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 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.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section F** of this *Evidence of Coverage*).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what's covered for you. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or NJ FamilyCare. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or “fast coverage decision” or “fast appeal” of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- The State Health Insurance Assistance Program (SHIP), which can be reached at **1-800-792-8820** (**TTY: 711**).
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or

appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.** **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F,** "Medical care"
- **Section G,** "Medicare Part D drugs"
- **Section H,** "Asking us to cover a longer hospital stay"
- **Section I,** "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page. You can also get help or information from government organizations such as your SHIP program at **1-800-792-8820** (**TTY: 711**).

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Evidence of Coverage* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

What you can do: You can ask us to make a coverage decision. Refer to **Section F2.**

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.
   What you can do: You can appeal our decision. Refer to **Section F3.**
3. You got medical care that you think we cover, but we won't pay.
   What you can do: You can appeal our decision not to pay. Refer to **Section F5.**
4. You got and paid for medical care you thought we cover, and you want us to pay you back.
   What you can do: You can ask us to pay you back. Refer to **Section F5**.
5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.
   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4.**
   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **integrated organization determination.**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-844-362-0934 (**TTY:** 711).
- Faxing: 1-833-322-0034.
- Writing:
  Aetna Medicare FIDE (HMO D-SNP)
  PO Box 818051
  Cleveland, OH 44181-8051

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **Seven calendar days** after we get your request **for a medical service or item that's subject to our prior authorization rules.**
- **14 calendar days** after we get your request **for all other** medical services or items,
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The

process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K.**

Fast coverage decision

The legal term for fast coverage decision is **expedited determination.**

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get.** You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, 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 you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your representative must contact us. Call us at **1-844-362-0934** (**TTY: 711**).

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-844-362-0934** (**TTY: 711**).

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.

- How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we tell you we're stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within ten calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, 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 it. If we deny a fast appeal we'll give you, your doctor, prescriber, or representative verbal confirmation of the denial.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options.
- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within seven calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within seven calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a NJ FamilyCare service or item, the letter tells you how to file a Level 2 Appeal yourself. The IRO will notify you in writing when it gets your appeal.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, NJ FamilyCare, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that NJ FamilyCare usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and NJ FamilyCare** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information

about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by NJ FamilyCare, your benefits for that service continue if you submit a Level 2 Appeal within ten calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity,** sometimes called the **IRE.**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within seven calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited**

requests.

- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and NJ FamilyCare

A Level 2 Appeal for services that NJ FamilyCare usually covers gives you two options. One option is an appeal with the IURO, the state's Independent Utilization Review Organization. The second option is a Fair Hearing with the state. You must request an IURO appeal **within 60 calendar days** of the date we sent the decision letter on your Level 1 Appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

How do I request an IURO appeal?

- The Independent Utilization Review Organization (IURO) is an independent organization that's hired by the State of New Jersey's Department of Banking and Insurance (DOBI). This organization isn't connected with us, and it isn't a government agency. This organization is chosen by the DOBI to serve as an independent reviewer for medical appeals, and the DOBI administers the IURO appeal process. A review by the IURO is also sometimes called an "IURO appeal" or an "External Appeal."
- The IURO will typically not review cases based on the following services:
  - assisted living program
  - assisted living services - when the denial isn't based on medical necessity
  - caregiver/participant training
  - chore services
  - community transition services
  - home based supportive care
  - home-delivered meals
  - personal care assistance (PCA)
  - respite (daily and hourly)
  - social day care

  - structured day program -- when the denial isn't based on medical necessity
  - supported day services -- when the denial isn't based on the diagnosis of TBI
- The IURO appeal process is optional. You can request an IURO appeal, and wait to receive the IURO's decision, before you request a Fair Hearing. Or, you can request an IURO appeal and a Fair Hearing at the same time (the requests are made to two different organizations). **You aren't required to request an IURO appeal before requesting a Fair Hearing.**
- You can request an IURO appeal yourself, or it can be requested by your authorized representative (which includes your provider, if they're acting on your behalf with your written consent).
- You can request an IURO appeal by filling out the *External Appeal Application* form. A copy of the *External Appeal Application* form will be sent to you with the decision letter for your Level 1 Appeal. You must send this form to the following address **within 60 calendar days** of the date on the decision letter for your Level 1 appeal:

  Maximus Federal – NJ IHCAP
  3750 Monroe Avenue, Suite 705
  Pittsford, NY 14534

  You may also fax the form to **585-425-5296**, or request an appeal online at **njihcap.maximus.com**.

- If you're appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your IURO appeal, you must request the IURO appeal **within ten calendar days** of the date on the decision letter for your Level 1 appeal.
- If the IURO reviews your case, it will reach a decision **within 45 calendar days** (or sooner, if your medical condition makes it necessary). If your IURO appeal is a "fast" appeal, the IURO will reach a decision **within 48 hours**.
- If you have questions about the IURO appeal process and/or need assistance with your application, you can call the New Jersey Department of Banking and Insurance toll-free at **1-888-393-1062** or **609-777-9470**, or email **ihcap@dobi.nj.gov**. You can also ask Maximus Federal directly by emailing them at **stateappealseast@maximus.com**.

How do I request a Fair Hearing?

- You must ask for a Fair Hearing in writing **within 120 calendar days** of the date that we sent the decision letter on your Level 1 Appeal. The letter you get from us will tell you where to submit your hearing request.
- If you ask for an expedited, or "fast" Fair Hearing, and you meet all of the requirements for a "fast" hearing, a decision will be made within 72 hours of the agency's receipt of your hearing request.
- However, if you're appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your Fair Hearing, you must request that your benefits be continued **in writing** on your Fair Hearing request, and you must send your request **within ten calendar days** of the date on the decision letter for your Level 1 appeal.

  Or, if you asked for an IURO appeal and received an adverse decision before requesting a Fair

Hearing, you must send this written request **within ten calendar days** of the date on the letter informing you of the adverse decision on your IURO appeal.

Please note that if you ask to have your services or items continue during a Fair Hearing and the final decision isn't in your favor, you may be required to pay for the cost of the services or items.

The Fair Hearing office gives you their decision in writing and explains the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or items.

For more information, refer to **Chapter 7** of this *Evidence of Coverage.* It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you

we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in **Section F3.** When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and NJ FamilyCare usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4**, for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that NJ FamilyCare may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Evidence of Coverage* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's *Drug List* or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

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

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our *Drug List* or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our *Drug List*, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2,** then refer to **Sections G3 and G4.**	Refer to **Section G4.**	Refer to **Section G4.**	Refer to **Section G5.**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on a drug is sometimes called asking for a **formulary exception.**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug that isn't on our *Drug List*

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Evidence of Coverage* for more information).
- Extra rules and restrictions for certain drugs include:

  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for 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* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No.**

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-844-362-0934** (**TTY: 711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Evidence of Coverage.*
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K.**

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

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

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells

you how to make an appeal.

Deadlines for a standard coverage decision about 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 send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling 1-844-362-0934 (**TTY:** 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.

  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within seven calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within seven calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than seven calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought within **30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE."**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the

IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file." **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within seven calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:

- Decide if you want to make a Level 3 Appeal.
- Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Evidence of Coverage.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (**1-800-633-4227**) 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy

before you're discharged. You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**.
- Visit **www.cms.gov/Medicare/Medicare-General-Information/BNI**.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In New Jersey, the QIO is Commence Health. Call them at **1-866-815-5440** (**TTY: 711**). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2.**

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (**TTY: 711**).

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (**1-800-633-4227**). (TTY users should call **1-877-486-2048**) You can also refer to a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI**.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-866-815-5440** (**TTY: 711**).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (**TTY: 711**).
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this *Evidence of Coverage* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal".** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the

"Notice of Medicare Non-Coverage" we sent you.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to Section I4.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage."**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-866-815-5440 (**TTY:** 711).

You must ask for this review within **60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.

- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional NJ FamilyCare appeals

You may also have other appeal rights if your appeal is about services or items that NJ FamilyCare usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare 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 on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should've received. • You think written information we sent you is too difficult to understand.

Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Member Services at **1-844-362-0934** (**TTY: 711**).

The legal term for a "complaint" is a ***"grievance."***

The legal term for "making a complaint" is ***"filing a grievance."***

K2. Internal complaints

To make an internal complaint, call Member Services at **1-844-362-0934** (**TTY: 711**). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.
- To file a grievance (complaint) in writing, send us your written complaint to
  Aetna Duals Grievances
  PO Box 14725
  Lexington, KY 40512
  - Please be sure you provide all pertinent information, including any supporting documents you believe are appropriate.
  - Your issue will be investigated by a member of our complaint team. If you submit your complaint verbally or in writing, we will inform you the result of our review in writing. Our notice will include a description of our understanding of your complaint and our resolution 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 legal term for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: **www.medicare.gov/MedicareComplaintForm/home.aspx.** You don't need to file a complaint with Aetna Medicare FIDE (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. The call is free. You can also contact the state's Medicaid program with a complaint by calling the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) at **1-800-701-0710** (TTY: **711**).

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can visit **www.hhs.gov/ocr** for more information.

You may also contact the local OCR office at:

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Customer Response Center: **1-800-368-1019**
Fax: **1-202-619-3818**
TDD: **1-800-537-7697**
Email: **OCRComplaint@hhs.gov**

You may also have rights under the Americans with Disability Act (ADA) and under the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason. If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** (**TTY: 1-800-537-7697**) or your local Office for Civil Rights. You can also contact and review information from the Department of Health and Human Services' Office for Civil Rights at **https://www.hhs.gov/ocr/index.html**. If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this *Evidence of Coverage*.

In New Jersey, the QIO is called Commence Health. The phone number for Commence Health is **1-866-815-5440** (**TTY: 711**).

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and NJ FamilyCare (Medicaid) programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

Table of Contents

Chapter 10 Ending your membership in our plan

A. When you can end your membership in our plan **169**

B. How to end your membership in our plan **169**

C. How to get Medicare and NJ FamilyCare services separately **170**

- **C1. Your Medicare services** **170**
- **C2. Your NJ FamilyCare services** **174**

D. Your medical items, services and drugs until your membership in our plan ends **174**

E. Other situations when your membership in our plan ends **175**

F. Rules against asking you to leave our plan for any health–related reason **175**

G. Your right to make a complaint if we end your membership in our plan **176**

H. How to get more information about ending your plan membership **176**

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have NJ FamilyCare, you have some choices to end your membership with our plan including any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period,** which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for NJ FamilyCare or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to leave our plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. If you enroll in another plan, your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1.**
- Medicaid services in **Section C2.**

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**.
- The State Health Insurance Assistance Program (SHIP), at **1-800-792-8820** (**TTY: 711**).

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Evidence of Coverage* for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership you can do so by enrolling in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't

selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users (people who have difficulty with hearing or speaking) should call **1-877-486-2048**. When you call 1-800-MEDICARE (**1-800-633-4227**), you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C1**.

C. How to get Medicare and NJ FamilyCare services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-Inclusive Care for the Elderly (PACE) plan, if you qualify	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call **1-800-792-8820** (TTY: **711**). If you need help or more information: • Call the New Jersey SHIP at **1-800-792-8820** (**TTY: 711**). Their website can be found at **nj.gov/humanservices/doas/services/q-z/ship/**. For more information or to find a local SHIP office in your area, please visit **nj.gov/humanservices/doas/services/q-z/ship/**. **OR** Enroll in a new integrated D-SNP, or in a PACE plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your NJ FamilyCare (Medicaid) coverage will also be shifted to the new D-SNP or PACE plan, and will be covered through that new plan.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare drug plan	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. If you need help or more information: • Call the New Jersey SHIP at **1-800-792-8820** (**TTY: 711**). Their website can be found at **nj.gov/humanservices/doas/services/q-z/ship/**. For more information or to find a local SHIP office in your area, please visit **nj.gov/humanservices/doas/services/q-z/ship/**. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your NJ FamilyCare (Medicaid) enrollment will automatically be changed to our NJ FamilyCare plan, Aetna Better Health of New Jersey. If you wish to change to a different NJ FamilyCare plan instead, please call NJ FamilyCare at **1-800-701-0710** (**TTY**: **711**)

3. You can change to:	**Here is what to do:**
Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason **NOTE:** 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 tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the New Jersey SHIP at **1-800-792-8820** (**TTY: 711**), Monday through Friday from 8:30 a.m. to 4:30 p.m. For more information or to find a local New Jersey SHIP office in your area, please visit **nj.gov/humanservices/doas/services/q-z/ship/**	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. If you need help or more information: • Call the New Jersey SHIP at **1-800-792-8820** (**TTY: 711**). Their website can be found at **nj.gov/humanservices/doas/services/q-z/ship/**. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey, for your NJ FamilyCare (Medicaid) benefits. Your new coverage will begin on the first day of the following month. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (**TTY: 711**)

4. You can change to:	**Here is what to do:**
Any Medicare health plan during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A.	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call **1-800-792-8820** (**TTY: 711**). If you need help or more information: • Call the New Jersey SHIP at **1-800-792-8820** (**TTY: 711**). Their website can be found at **nj.gov/humanservices/doas/services/q-z/ship/** **OR** Enroll in a new Medicare plan You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. You'll be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey, for your NJ FamilyCare (Medicaid) benefits. Your new coverage will begin on the first day of the following month. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (**TTY: 711**).

C2. Your NJ FamilyCare services

If you disenroll from this plan and make any of the choices listed from numbers two through four in the above chart, you'll automatically be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey, for your NJ FamilyCare (Medicaid) benefits. Your new coverage will begin on the first day of the following month. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710** (**TTY: 711**).

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.

- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in Aetna Medicare FIDE (HMO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you're away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or national, or an eligible non-citizen.
  - You must be a United States citizen or national, or an eligible non-citizen to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

If you lose your NJ FamilyCare eligibility but can be expected to regain it within three months, we'll continue to provide all Medicare and NJ FamilyCare covered benefits. During this time, we'll assist you to regain NJ FamilyCare eligibility. If you can't regain NJ FamilyCare eligibility within three months we'll disenroll you from Aetna Medicare FIDE (HMO D-SNP). If you regain NJ FamilyCare eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- 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.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health–related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY

users should call **1-877-486-2048**.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Evidence of Coverage* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

Table of Contents

Chapter 11 Legal notices

A. Notice about laws **178**

B. Notice about nondiscrimination **178**

C. Notice about Medicare as a second payer and NJ FamilyCare as a payer of last resort **178**

A. Notice about laws

Many laws apply to this *Evidence of Coverage.* These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Evidence of Coverage.* The main laws that apply are federal laws about the Medicare and NJ FamilyCare (Medicaid) programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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 users can call **1-800-537-7697**. You can also visit **HHS.gov/ocr/index.html** for more information.
- Call your local Office for Civil Rights. You can reach the New Jersey Division on Civil Rights at **1-833-653-2748** (**TTY: 711**), and you can learn how to file a complaint online at **https://www.njoag.gov/about/divisions-and-offices/division-on-civil-rights-home/division-on-civil-rights-file-a-complaint/**.
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and NJ FamilyCare as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that NJ FamilyCare is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Evidence of Coverage* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Evidence of Coverage* explains appeals, including how to make an appeal.

Behavioral health: An all-inclusive term referring to mental health and substance use disorders.

Biological product: A 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 getting a new prescription. (Go to "Interchangeable biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized care plan."

Care team: Refer to "Interdisciplinary care team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this *Evidence of Coverage* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services. **Chapter 9** of this *Evidence of Coverage* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Management Program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are 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 and supplies, nebulizers, and walkers.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

***Evidence of Coverage* and disclosure information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded services: Services that aren't covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. A FIDE SNP covers both Medicare and Medicaid under a single health plan. Our plan is a FIDE SNP.

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

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 (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of six months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you for services. Call Member Services if you get any bills you don't understand. Because we pay the entire cost for your services, you don't owe any cost sharing. Providers shouldn't bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. 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. The formal name is the **Independent Review Entity.**

Individualized care plan (ICP or care plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable biosimilar: A biosimilar that may be substituted 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.

Interdisciplinary care team (ICT or care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

***List of Covered Drugs* (*Drug List*):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The List of Covered Drugs tells you if there are any rules you need to follow to get your drugs. The List of Covered Drugs is sometimes called a "formulary."

Low Income Subsidy (LIS): Refer to "Extra Help."

Managed Long-term services and supports (MLTSS): Managed Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. MLTSS includes Community-based Services and Nursing Facilities (NF).

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare Diabetes Prevention Program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA," that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): 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. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Evidence of Coverage* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

NJ FamilyCare: This is the name of New Jersey's Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of this *Evidence of Coverage*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered. Organization determinations are called "coverage decisions". **Chapter 9** of this *Evidence of Coverage* explains coverage decisions.

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's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Evidence of Coverage* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a healthcare professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

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 use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Evidence of Coverage* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Evidence of Coverage*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our plan website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't 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 doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Evidence of Coverage* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes alternative drugs 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 drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. You can find more information about referrals in **Chapters 3 and 4** of this *Evidence of Coverage*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy. Refer to **Chapter 4** of this *Evidence of Coverage* to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State fair hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Fair Hearing. If the State Fair Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

Aetna Medicare FIDE (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	1-844-362-0934 (**TTY:** 711) Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
FAX	1-855-259-2087
WRITE	Aetna Medicare FIDE (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	Go to **AetnaMedicare.com/NJDSNP** 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:

CALL	1-800-792-8820 Monday–Friday 8:30 AM to 4:30 PM
TTY	711
WRITE	NJ State Health Insurance Assistance Program PO Box 807 Trenton, NJ 08625
WEBSITE	nj.gov/humanservices/doas/services/q-z/ship/

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 0938-1444. 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.*
20260908