Aetna Medicare HIDE (HMO D-SNP) *Member Handbook*

January 1, 2027 – December 31, 2027

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

Member Handbook Introduction

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

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

When this *Member Handbook* says "we," "us," "our," or "our plan," it means Aetna Medicare HIDE (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 HIDE (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.

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 1-855-676-5772 (**TTY:** 711). Someone that speaks Spanish can help you. This is a free service.

For questions about or problems with the MI Coordinated Health program or our plan, contact the MI Community, Home, and Health Ombudsman (MI CHHO) for free help. MI CHHO is an independent program and isn't connected with this plan. Call **1-888-746-6456** or visit the MI CHHO website at **meji.org/michho/mhlo**. To schedule an appointment with a person-centered options counselor, please call MI Options at **1-800-803-7174** 8 a.m. to 8 p.m., Monday through Friday.

Si tiene preguntas o problemas con el programa MI Coordinated Health o con nuestro plan, comuníquese con el Defensor del Pueblo de la Comunidad, el Hogar y la Salud de MI (CHHO de MI) para obtener ayuda gratuita. El CHHO de MI es un programa independiente y no está relacionado con este plan. Llame al **1-888-746-6456** o visite el sitio web del CHHO de MI en **meji.org/michho**. Para programar una cita con un asesor de opciones centradas en la persona, llame a MI Options al **1-800-803-7174** de lunes a viernes, de 08:00 a. m. a 08:00 p. m.

Notice of Availability (NOA)

TTY: 711

To access language assistance services and appropriate auxiliary aids and services at no cost to you, call the number on your ID card. (English)

የቋንቋ እርዳታ አገልግሎቶችን እና ተገቢ የሆኑ ተጨማሪ አጋዥ ድጋፎችን እና አገልግሎቶችን ያለ ምንም ክፍያ ለማግኘት በመታወቂያ ካርድዎ ላይ ወዳለው ቁጥር ይደውሉ። (Amharic)

للوصول إلى خدمات المساعدة اللغوية والمساعدات والخدمات المساعدة المناسبة دون أي تكلفة عليك، اتصل بالرقم الموجود على بطاقة ID الخاصة بك. (Arabic)

如欲免費獲得語言輔助服務以及適當的輔助工具和服務，請撥打您的 ID 卡上的電話號碼。 (Chinese)

Pou w jwenn aksè a sèvis asistans lang ak èd ak sèvis oksilyè apwopriye san w pa peye anyen, rele nimewo ki sou kat idantite w la. (French Creole)

Pour accéder gratuitement aux services d’assistance linguistique et aux aides et services auxiliaires appropriés, veuillez appeler le numéro figurant sur votre carte d’identité. (French)

Um Sprachunterstützung sowie geeignete Hilfsmittel und Dienstleistungen kostenlos in Anspruch zu nehmen, rufen Sie bitte die auf Ihrem Ausweis angegebene Nummer an. (German)

Per accedere ai servizi di assistenza linguistica, agli ausili e ai servizi accessori pertinenti a titolo gratuito, chiama il numero riportato sulla tua tessera identificativa. (Italian)

તમારા માટે કોઈપણ ખર્ચ વિના ભાષાકીય સહાય સેવાઓ અને યોગ્ય સહાયક સહાય તથા સેવાઓ મેળવવા માટે, તમારા ID કાર્ડ પર આપેલા નંબર પર કૉલ કરો. (Gujarati)

No ke komo ‘ana i nā lawelawe kōkua ‘ōlelo a me nā mea kōkua kūpono me ka uku ‘ole iā ‘oe, e kelepona i ka helu ma kāu kāleka ID. (Hawaiian)

Kom siv tau cov kev pab cuam txhais lus thiab cov khoom pab kom hnov lus thiab cov kev pab cuam yam tsis sau nqi ntawm koj, hu tus xov tooj nyob ntawm koj daim npav ID. (Hmong):

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言語支援サービスや適切な補助補助具・サービスを無料で利用するには、IDカードに登録された番号にお電話ください。 (Japanese)

လာကမၤန့ၢ် ကျိာ်အတၢ်ဆီဉ်ထွဲမၤစၢၤတၢ်မၤဒီး တၢ်နၢ်ဟူ အပီးအလိ လၢအကြၢးအ ဘဉ်တဖဉ် ဒီးတၢ်မၤစၢၤတၢ်မၤ လၢအဘူးအလဲတအိဉ်ဘဉ်တဖဉ်အဂီၢ်, ကိးလီတဲစိ နီဉ်ဂံၢ်အံၤ ဖဲ နၤ ID ခးကဲ့အပူၤတက့ၢ်. (Karen)

언어 지원 서비스와 적절한 보조 지원 및 서비스를 무료로 이용하려면 ID 카드에 있는 번호로 전화하십시오. (Korean)

Deeggarsa afaanifi tajaajilawwanii akkasumas deeggarsaafi tajaajila dabalataa kaffaltiirraa bilisaa argachuuf lakkoofsa Waraqaa Eenyummaa keessanirra jirutti bilbilaa. (Oromo)

ເພື່ອເຂົ້າເຖິງການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ອຸປະກອນຊ່ວຍໃນການຟັງ ແລະ ການບໍລິການ ທີ່ເໝາະສົມໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍຕ່າທ່ານ, ໃຫ້ໂທຫາເບີ໋ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Laotian)

ដើម្បីទទួលបានសេវាជំនួយផ្នែកភាសា ព្រមទាំងឧបករណ៍ និងសេវាជំនួយបន្ថែមសមរម្យ ដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណ ID របស់អ្នក។ (Khmer)

برای دسترسی رایگان به خدمات کمک زبانی و مساعدتهای جانبی مناسب با شماره مندرج روی کارت ID خود تماس بگیرید. (Persian)

Aby skorzystać z usług pomocy językowej oraz odpowiednich środków pomocniczych i usług bez ponoszenia żadnych kosztów, zadzwoń pod numer podany na karcie identyfikacyjnej. (Polish)

Para aceder, sem qualquer custo para si, a serviços de assistência linguística e a ajudas e serviços auxiliares adequados, ligue para o número indicado no seu cartão de identificação. (Portuguese)

Чтобы получить бесплатный доступ к услугам языковой поддержки и соответствующим вспомогательным средствам и услугам, позвоните по номеру, указанному на вашей идентификационной карте. (Russian)

Para tener acceso a los servicios de asistencia en otros idiomas y a las ayudas y servicios auxiliares adecuados sin costo para usted, llame al número que figura en su tarjeta de identificación. (Spanish)

Para ma-access ang mga serbisyo ng tulong sa wika at mga naaangkop na karagdagang tulong at serbisyo nang walang bayad, tawagan ang numerong nasa iyong ID card. (Tagalog)

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? **If you have questions,** please call Aetna Medicare HIDE (HMO D-SNP) at **1-855-676-5772** (TTY: **711**), 8 AM to 8 PM, 7 days a week. The call is free. **For more information**, visit **AetnaMedicare.com/MICHDSNP**.

หากต้องการเข้าถึงบริการช่วยเหลือด้านภาษา รวมถึงอุปกรณ์และบริการช่วยเหลือพิเศษที่เหมาะสมโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อหมายเลขที่ระบุบนบัตรประจำตัวของคุณ (Thai)

Để được sử dụng miễn phí các dịch vụ hỗ trợ ngôn ngữ cùng các phương tiện và dịch vụ hỗ trợ phù hợp, vui lòng gọi đến số điện thoại ghi trên thẻ ID của quý vị. (Vietnamese)

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2027 MEMBER HANDBOOK

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Disclaimers

- Benefits and/or copayments 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 HIDE (HMO D-SNP) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members. Enrollment depends on contract renewal.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Aetna Medicare HIDE (HMO D-SNP), a health plan that covers or coordinates all of your Medicare and Michigan 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 *Member Handbook*.

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A. Welcome to our plan

Aetna Medicare HIDE (HMO D-SNP) is part of the MI Coordinated Health (MICH) program. MICH is a highly integrated dual-eligible special needs plan (HIDE SNP) that provides benefits of both Medicare and Medicaid to enrollees. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators 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 Michigan 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. Michigan Medicaid

Michigan Medicaid is the name of the Michigan Medicaid program. Michigan Medicaid is run by the state and is paid for by the state and the federal government. Michigan Medicaid helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) 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 Michigan approved our plan. You can get Medicare and Michigan Medicaid services through our plan as long as:

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

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

C. Advantages of our plan

You'll now get all your covered Medicare and Michigan Medicaid services from our plan, including drugs. **You don't pay extra 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 Coordinator. 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 Coordinator.
- Your care team and Care Coordinator 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.
- New members to Aetna Medicare HIDE (HMO D-SNP): In most instances you'll be enrolled in Aetna Medicare HIDE (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Aetna Medicare HIDE (HMO D-SNP). You may still receive your Michigan Medicaid benefits from your previous Michigan Medicaid health plan for one additional month. After that, you'll receive your Michigan Medicaid services through Aetna Medicare HIDE (HMO D-SNP). There will be no gap in your Michigan Medicaid coverage. Please call us at the number at the bottom of the page if you have any questions.

D. Our plan's service area

Our service area includes these counties in **Michigan**: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne.

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 *Member Handbook* 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 Michigan Medicaid, **and**
- don't live in a state-operated veteran's home, **and**
- aren't currently enrolled in hospice care, **and**
- aren't currently enrolled in MI Choice waiver program, **and**
- aren't currently enrolled in the Program of All-inclusive Care for the Elderly (PACE), **and**
- are age 21 or older at the time of enrollment including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program **and**
- are receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount).

If you lose your Michigan Medicaid eligibility but can be expected to regain it within three months, we'll continue to provide all Medicare benefits covered by Aetna Medicare HIDE (HMO D-SNP). When your Michigan Medicaid coverage ends, we won't pay for your Michigan Medicaid benefits. You will have to pay for any services that you continue to receive that are usually covered by Michigan Medicaid while you're still enrolled with us for your Medicare coverage. We won't continue to cover Medicaid benefits that are included under the Michigan Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period. For more information, please contact your care coordinator or Member Services by calling the phone number listed on the bottom of this page.

We'll assist you to regain your Michigan Medicaid eligibility. If your Michigan Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage:

- Your enrollment with our plan will continue.
- We'll resume paying for your Michigan Medicaid benefits.
- During the Medicaid eligibility review process, you may be responsible for certain copayments or coinsurance amounts for Medicare covered services that Medicaid would normally cover. If you regain Medicaid eligibility within 3 months, coverage may be applied retroactively, and you may be reimbursed for eligible out-of-pocket costs you paid for Medicare-covered services during that period.

If you can't regain Michigan Medicaid within three month(s) we'll disenroll you from Aetna Medicare HIDE (HMO D-SNP). If you regain Michigan Medicaid 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.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit or telephone call. 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.

Aetna Medicare HIDE (HMO D-SNP) must maintain your current providers and services you're receiving at the time of Enrollment. This includes drugs and providers which aren't part of our network. How long you'll continue to receive these services depends on what services you're receiving and why you're getting them. Only after we've completed your HRA will we consider any changes to the services you're getting at the time you enroll.

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 coordinator, your specialists, or other health professionals that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator 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 coordinator 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 LTSS or other services. The care plan will focus on your goals taking into account your concerns, wants, needs and strengths. It'll include a summary of your health status and your plan for addressing your concerns. You'll be asked to sign your care plan after it's satisfactory to you.
Your care plan includes:

- your health care goals,
- a timeline for getting the services you need,
- your cultural values and the communication needs and preferences,
- your preferences for care, services, and supports,
- your prioritized list of concerns, goals and objectives, and strengths,
- specific providers, supports and services including amount, scope, and duration,
- a summary of your health status,
- the plan for addressing your concerns or goals and measures for achieving them,
- the person(s) responsible for helping you achieve your goals,
- due dates for the interventions and Reassessment, **and**
- a plan to address health related social needs such as food or housing security.

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

Your costs may include the following:

- Medicare Prescription Payment Plan Amount **(Section H1)**.

The "Extra Help" program helps people with limited resources pay for their drugs. Learn more about this program in **Chapter 2, Section I**.

We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services at the number at the bottom of this page and ask for the "LIS Rider".

H1. Medicare Prescription Payment Amount

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

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

I. This *Member Handbook*

This *Member Handbook* 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 *Member Handbook* or call 1-800-MEDICARE (**1-800-633-4227**).

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

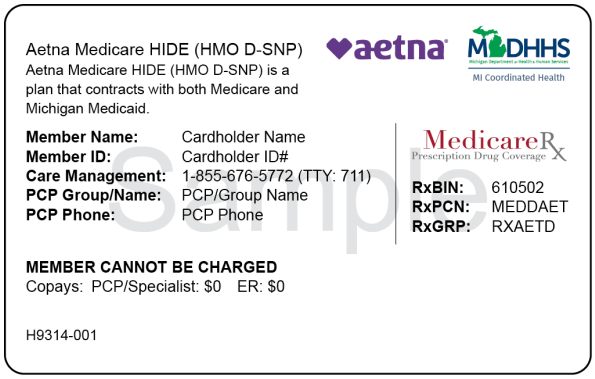
The contract is in effect for the months you're enrolled in our plan between January 1, 2027 and December 31, 2027.

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 or Formulary.*

J1. Your Member ID Card

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


Aetna Medicare HIDE (HMO D-SNP)
Aetna Medicare HIDE (HMO D-SNP) is a plan that contracts with both Medicare and Michigan Medicaid.

aetna
MDHHS
MI Coordinated Health

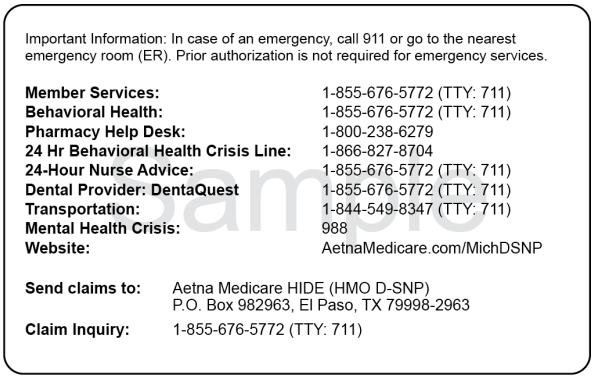
Member Name: Cardholder Name
Member ID: Cardholder ID#
Care Management: 1-855-676-5772 (TTY: 711)
PCP Group/Name: PCP/Group Name
PCP Phone: PCP Phone

MedicareRx
Prescription Drug Coverage
RxBIN: 610502
RxPCN: MEDDAET
RxGRP: RXAETD

MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: $0 ER: $0

H9314-001

Sample Sample


Important Information: In case of an emergency, call 911 or go to the nearest emergency room (ER). Prior authorization is not required for emergency services.

Member Services:	1-855-676-5772 (TTY: 711)
Behavioral Health:	1-855-676-5772 (TTY: 711)
Pharmacy Help Desk:	1-800-238-6279
24 Hr Behavioral Health Crisis Line:	1-866-827-8704
24-Hour Nurse Advice:	1-855-676-5772 (TTY: 711)
Dental Provider: DentaQuest	1-855-676-5772 (TTY: 711)
Transportation:	1-844-549-8347 (TTY: 711)
Mental Health Crisis:	988
Website:	AetnaMedicare.com/MichDSNP

Send claims to: Aetna Medicare HIDE (HMO D-SNP)
P.O. Box 982963, El Paso, TX 79998-2963

Claim Inquiry: 1-855-676-5772 (TTY: 711)

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 Michigan Medicaid 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 *Member Handbook* 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. During the first 90 days after you enroll with Aetna Medicare HIDE (HMO D-SNP), you can see any provider you've seen within the previous twelve (12) months, even if the provider isn't in our network. 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**
  - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, dentists, 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 help you 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 HIDE (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 *Member Handbook* 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. The *Drug List* will include a section that lists all Medicaid drugs covered in our plan. This information will also be found at our website or by calling your care coordinator or Member Services.

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 such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Member Handbook* 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 and your cost-sharing amounts. 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 *Member Handbook*.

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 Coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Member Services

CALL	1-855-676-5772 (**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 HIDE (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	AetnaMedicare.com/MICHDSNP

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 **or**
        - the amount we pay for your health 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 *Member Handbook.*
- 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 *Member Handbook* 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 1-855-676-5772 (**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 MI Community, Home, and Health Ombudsman (MI CHHO) to help you with your complaint. MI CHHO can be reached at 1-888-746-6456 or meji.org/michho/contact-michho.

  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs and medications covered by Michigan Medicaid.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- 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 *Member Handbook*.
- 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 *Member Handbook*.
- 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 *Member Handbook*.
  - 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 *Member Handbook*.

B. Your Care Coordinator

A Care Coordinator is a health professional who will help you get care and services that affect your health and wellbeing. You are assigned a Care Coordinator when you enroll with Aetna Medicare HIDE (HMO D-SNP). Your Care Coordinator will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your Care Coordinator and set goals for healthy living. Whenever you have a question or a problem about your health or services or care you are getting from us, you can call your Care Coordinator. **Your Care Coordinator is your "go-to" person** for Aetna Medicare HIDE (HMO D-SNP).

Our goal in Aetna Medicare HIDE (HMO D-SNP) is to meet your needs in a way that works for you. This is why we call our program "person-centered." The person-centered planning process is when you work with your Care Coordinator to create a care plan that is about your goals, choices, and abilities. When you create your care plan, you are welcome to involve people you feel are key to your success, such as family members, friends, or legal representatives.

CALL	1-855-676-5772 (**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 HIDE (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998

Contact your Care Coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about getting long-term services and supports services (including adult day care, personal care, respite care and helping to transition from community to a nursing facility)
- coordinating services you receive in fee-for-service Medicaid

C. MI Options

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 Michigan, the SHIP is called MI Options.

MI Options 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	**1-800-803-7174** Monday–Friday 8:00 AM to 8:00 PM Please note that this is the main MI Options call center. There are several MI Options entities contracted throughout the state and their hours of operation may vary depending on the location.
TTY	**711**
EMAIL	**MDHHS-MIOPTIONS@Michigan.gov**
WRITE	MI Options PO Box 30676 Lansing, MI 48909
WEBSITE	**michigan.gov/MDHHSMIOptions**

Contact MI Options for help with:

- questions about Medicare
- MI Options 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 for quality improvement. 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	1-888-524-9900 This call is free.
TTY	The QIO uses a direct TTY number. The TTY phone number is 1-888-985-8775. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Commence Health 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
WEBSITE	commencehealthqio.cms.gov/en

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. Michigan Medicaid

Michigan Medicaid 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 Beneficiary Help Line: **1-800-642-3195** or go to **www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support**.

CALL	Beneficiary Help Line **1-800-642-3195** 8 a.m. – 7 p.m. Monday through Friday (except holidays)
TTY	**711**
WRITE	400 S. Pine St. 5th Floor Lansing, MI 48933
EMAIL	**beneficiarysupport@michigan.gov**

WEBSITE	www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support

G. MI Community, Home, and Health Ombudsman (MI CHHO)

The MI CHHO 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 MI CHHO 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	1-888-746-MHLO (1-888-746-6456) 9 a.m. - 5 p.m. Monday - Friday
TTY	711
WRITE	15851 S. US 27, Suite 73, Lansing, MI 48906
EMAIL	MI-CHHO@meji.org
WEBSITE	meji.org/michho

H. Michigan Long–Term Care Ombudsman Program (MLTCOP)

The Michigan Long–Term Care Ombudsman Program (MLTCOP) helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The Michigan Long–Term Care Ombudsman Program (MLTCOP) isn't connected with our plan or any insurance company or health plan.

CALL	1-866-485-9393, 517-827-8040 Monday–Friday 8:00 AM to 5:00 PM
TTY	711
WRITE	MLTCOP - MEJI 15851 S. US 27, Suite 73, Lansing, MI 48906
EMAIL	MLTCOP@meji.org
WEBSITE	mltcop.org/

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

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

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

Method	Best Available Evidence – Contact Information
WRITE	Best Available Evidence PO Box 14076 Lexington, KY 40512
FAX	1-866-756-5522
EMAIL	BAE/LISmailbox@aetna.com

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

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 a.m. to 7 p.m., 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. Other resources

LOCAL AREA AGENCY	CALL	WEBSITE AND AREA SERVED
Area Agency on Aging 1A	1-313-446-4444	DetroitSeniorSolution.org/ County served: Wayne (Detroit area)
Area Agency on Aging 1B	1-800-852-7795	AAA1b.org Counties served: Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw



If you have questions, please call Aetna Medicare HIDE (HMO D-SNP) at 1-855-676-5772 (TTY: 711), 8 AM to 8 PM, 7 days a week. The call is free. **For more information**, visit AetnaMedicare.com/MICHDSNP.

LOCAL AREA AGENCY	CALL	WEBSITE AND AREA SERVED
The Senior Alliance - Area Agency on Aging 1C	1-734-722-2830	TheSeniorAlliance.org/ Counties served: Southern and Western Wayne
Area Agency on Aging 3A	1-269-373-5173	Kalcounty.gov/AAA County served: Kalamazoo
Carewell Services Area Agency on Aging 3B	1-269-966-2450 1-800-626-6719 (outside Calhoun County)	CarewellServices.org/ Counties served: Barry and Calhoun
Area Agency on Aging 3C	1-517-278-2538	BHSJ.org/aaa Counties served: Branch and St. Joseph
Area Agency on Aging Region IV	1-800-654-2810	AreaAgencyonAging.org Counties served: Berrien, Cass, and Van Buren

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 Coordinator, 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 *Member Handbook*.

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A. Information about services and providers

Services are health care, long-term supports and services (LTSS), 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 LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

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 LTSS.

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 Michigan Medicaid. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, covered behavioral health services, and LTSS 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 *Member Handbook.*
- 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 a referral 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 Coordinator

C1. What a Care Coordinator is

Your Care Coordinator will help establish priorities and to link all of your doctors, pharmacies, behavioral health care and long-term care supports and services through your health plan. The Care Coordinator will help make sure that your doctors and other providers work together to meet your needs and honor your choices. The Care Coordinator connects you to supports and services that you need to be healthy and to live where you wish. This person will assist with your care plan, answer your questions, help get appointments and services, arrange transportation, and more.

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/MICHDSNP**. You can also learn more about health programs and care management services designed to help you stay healthy and manage your health care needs here: **https://www.aetna.com/content/dam/aetna/medicaid/michigan-hide-dsnp/pdfs/PHMprograms.pdf**.

C2. How you can contact your care coordinator

You can contact your care coordinator by calling **1-855-676-5772** (**TTY:** **711**) or Member Services at the number at the bottom of the page. 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 case management or to request a referral, call **1-855-676-5772** (**TTY:** **711**), visit us online at **AetnaMedicare.com/MICHDSNP** or learn more here: **https://www.aetna.com/content/dam/aetna/medicaid/michigan-hide-dsnp/pdfs/PHMprograms.pdf**.

C3. How you can change your care coordinator

You can request to change your care coordinator at any time by calling Member Services 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/MICHDSNP** 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/MICHDSNP**, 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.

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/MICHDSNP** 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.
- 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.
- 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.)

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 three 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 Michigan Medicaid 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.

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

- We can't pay a provider who isn't eligible to participate in Medicare and/or Michigan Medicaid.
- 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. Long–term services and supports (LTSS)

Long-Term Supports and Services (LTSS) are services that help elderly people and people with disabilities meet their daily needs for help and improve the quality of their lives. Examples of LTSS include help with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, usually in homes and communities, but also in nursing homes and other facilities.

As an Aetna Medicare HIDE (HMO D-SNP) member, you may qualify to receive long-term supports and

services (LTSS) in a nursing facility or at home. LTSS provides assistance to help you stay at home instead of going to a nursing home or hospital, or may assist you to transition from the nursing facility to the community. LTSS can provide assistance with bathing, dressing and other basic activities of daily living. LTSS may also include home modification, adaptive equipment and supplies, and chore services.

To qualify for these services, you must meet nursing facility level of care. Your Care Coordinator will meet with you and assess your needs. Once you qualify for these services, we will re-assess you each year to see if the services are meeting your needs. If you have questions about LTSS or to see if you qualify, call your Care Coordinator.

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

All Medicaid and Medicare behavioral health services are covered by your plan. All existing Medicare and Medicaid behavioral health services will continue to be provided for people currently receiving care and who enroll in the MI Coordinated Health (MICH) program. Certain behavioral health services covered by Medicaid are managed by Michigan Pre-paid Inpatient Health Plans (PIHPs), organizations that the Michigan Department of Health and Human Services contracts with to administer Medicaid covered behavioral health benefits. All Medicaid covered Behavioral Health services not managed by the PIHPs and all behavioral health services covered by Medicare will be managed by us. If you have questions about behavioral health, contact your Care Coordinator.

G. How to get self–directed care

G1. What self–directed care is

You have the option to self-direct your services if you qualify. You would control a budget and have the right to hire and manage personal care workers and other providers.

- This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget."
- If you choose to do so, you would also have control over the hiring and management of providers.

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

Your care coordinator will work with you to determine whether you qualify for self-directed services.

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

Talk to your care coordinator if you think you need services that can be self-directed.

H. Transportation services

We may be able to help you get to your medical appointments and, if you qualify, may be able to help with transportation for other things. If you need help with transportation, talk to your care coordinator.

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. However, you won't pay for emergency services if you delay telling us. Please call Member Services at **1-855-676-5772** (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 Medical 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 *Member Handbook*.

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.

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'll cover your care.

However, after the doctor says it wasn't an emergency, we'll 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/MICHDSNP**, 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 Medical 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/MICHDSNP**.

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 *Member Handbook* for more information.

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

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill. If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this *Member Handbook* 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 *Member Handbook*), **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 *Member Handbook* 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 Coordinator 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 *Member Handbook*.

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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 *Member Handbook.* This chapter also explains limits on some services.

Because you get help from Michigan Medicaid, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan's rules.

If you need help understanding what services are covered, call your Care Coordinator and/or Member Services at **1-855-676-5772** (**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 *Member Handbook* 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 Michigan Medicaid covered services according to the rules set by Medicare and Michigan Medicaid.
- The services (including medical care, behavioral health and substance abuse services, long-term services and supports, 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 *Member Handbook* has more information about using network and

out-of-network providers.

- You have a primary care provider (PCP) or a care team providing and managing your care.
- You can keep using your doctors and getting your current services for up to 90 days, or 180 days depending on the service, while your Care Plan is being completed. If you're currently under treatment with a provider that's out of Aetna Medicare HIDE (HMO D-SNP)'s network, or have an established relationship with a provider that's out of Aetna Medicare HIDE (HMO D-SNP)'s network, call Member Services to check about staying connected.
- 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 Michigan Medicaid eligibility but can be expected to regain it within three months, we'll continue to provide all Medicare benefits covered by Aetna Medicare HIDE (HMO D-SNP). When your Michigan Medicaid coverage ends, we won't pay for your Michigan Medicaid benefits. We won't continue to cover Medicaid benefits that are included under the Michigan Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period. For more information, please contact your care coordinator or Member Services by calling the phone number listed on the bottom of this page.

  We'll assist you to regain your Michigan Medicaid eligibility. If your Michigan Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage:
  - Your enrollment with our plan will continue.
  - We'll resume paying for your Michigan Medicaid benefits.
  - During the Medicaid eligibility review process, you may be responsible for certain copayments or coinsurance amounts for Medicare covered services that Medicaid would normally cover. If you regain Medicaid eligibility within 3 months, coverage may be applied retroactively, and you may be reimbursed for eligible out-of-pocket costs you paid for Medicare-covered services during that period.

  If you can't regain Michigan Medicaid within three months we'll disenroll you from Aetna Medicare HIDE (HMO D-SNP). If you regain Michigan Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

  Call Member Services for more information.
- 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/MIQualify**.
- 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
	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 up to 12 acupuncture visits in 90 days 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);	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Acupuncture *(continued)*	
	• not associated with surgery; • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. 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. 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	$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
	Aetna Medicare Extra Benefits Card *(continued)*	
	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. • 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).	
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Aetna Medicare Extra Benefits Card *(continued)*	
	• 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 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. **Prior authorization is required for non-emergency transportation.**	$0
	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	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Annual routine physical *(continued)*	
	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.)	
	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
	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 24 months	$0

	Covered Service	What you pay
	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 • 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.	$0
	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 once every five years (60 months). 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:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Cervical and vaginal cancer screening *(continued)*	
	• for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment In addition to Medicare-covered benefits, we also offer: • Certain (non-Medicare covered) chiropractic services: up to twelve visits every year including: ◦ Strapping/taping of joints only (does not include the neck or back) ◦ Plain x-rays ◦ Range of motion measurement and reporting ◦ Mechanical traction ◦ Attended electrical stimulation therapy ◦ Ultrasound therapy ◦ Extraspinal chiropractic manipulation An in-network provider must determine medical necessity for covered services. To locate a network provider, you may contact Member Services at the phone number on your member ID card or visit our online directory at **AetnaMedicare.com/findprovider**. If you choose to use a provider outside of the network, the services you receive will not be covered.	$0
	Colorectal cancer screening We pay for the following services:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Colorectal cancer screening *(continued)*	
	• 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. • 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.	

	Covered Service	What you pay
	Community Health Worker (CHW) Services CHWs are non-licensed public health providers who facilitate access to needed health and social services for members. CHW services focus on preventing disease, disability, and other chronic conditions or their progression, and promoting physical and mental health. CHW services must be recommended by a licensed provider. Conditions that may define a member's eligibility for CHW services include the following: • diagnosis of one or more chronic health conditions including behavioral health; • suspected or documented unmet health-related social needs; or • pregnancy and post partum	$0
	Counseling to stop smoking or tobacco use 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). In addition to Medicare-covered benefits, we also offer: • Additional (non-Medicare covered) individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	$0
	Dental services Aetna Medicare HIDE (HMO D-SNP) will pay for the following services:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Dental services *(continued)*	
	• examinations and evaluations are covered once every six months • cleaning is a covered benefit once every six months • silver diamine fluoride treatment is covered with a maximum of six applications per lifetime • X-rays ◦ bitewing x-rays are a covered benefit only once in a 12-month period ◦ a panoramic x-ray is a covered benefit once every five years ◦ a full mouth or complete series of x-rays is a covered benefit once every five years • fillings • tooth extractions • complete or partial dentures are covered once every five years • sealants are covered once every three years, if criteria are met • indirect restorations (crowns) are covered once every five years per tooth, if criteria are met • root canal therapy/re-treatment of previous root canal • comprehensive periodontal evaluation • scaling in presence of inflammation • periodontal scaling and root planning • other periodontal maintenance 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. We cover all dental services required by Medicaid. In addition, you get a combined annual benefit amount (allowance) of $2,000 for certain Medicare covered preventive and comprehensive dental services. Covered Medicare services will be paid to the provider up to the annual benefit amount (allowance). If you exceed the benefit amount for covered services, you will be responsible for those costs and will not be reimbursed.	
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Dental services *(continued)*	
	See the *Dental Schedule of Benefits* for more details. This benefit is provided through DentaQuest. If you choose a provider outside of the network, services will not be covered. To locate a network provider, you may: 1. Call DentaQuest Member Services at **1-844-870-3976** (**TTY: 711**) Or 2. Visit **dentaquest.com** and search using your Medicare plan **Prior authorization may be required and is the responsibility of your provider.**	
	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 Prevention Program services Our plan will pay for Medicare Diabetes Prevention Program services and Michigan Diabetes Prevention Program services: **Medicare Diabetes Prevention Program (MDPP)** • Our plan will pay 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 **Michigan Diabetes Prevention Program (MiDPP) services** • Our plan will pay for 28 structured health behavior change one-hour sessions provided by a Medicaid-enrolled Lifestyle Coach associated with an enrolled MiDPP provider for members who are overweight or obese as defined by Body Mass Index (BMI) and has one of the following:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Diabetes prevention program services *(continued)*	
	◦ elevated blood glucose levels according to CDC standards for blood glucose level requirements ◦ history of gestational diabetes mellitus (GDM) ◦ score at "high risk" on the CDC prediabetes risk test A member with previously diagnosed type 1 or type 2 diabetes or who's currently pregnant can't enroll in MiDPP.	
	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 ◦ 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:	$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, 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.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Diabetic self-management training, services, and supplies *(continued)*	
	◦ 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. **Prior authorization is required for more than one blood glucose monitor per year and/or test strips in excess of 100 strips per 30 days. Prior authorization may be required for diabetic shoes and inserts. Prior authorization is the responsibility of your provider.**	• 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 formulary guide. • 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:** • We cover all continuous glucose monitors (CGMs) at DME providers, but we exclusively cover Dexcom and Freestyle Libre at network pharmacies.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Diabetic self-management training, services, and supplies *(continued)*	
		• 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/MICHDSNP** **Prior authorization may be required and is the responsibility of your provider.**
	Doula services The plan will pay for different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas. The plan will pay for 12 total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. Additional visits may be requested. Doula support during the perinatal period may include, but isn't limited to:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Doula services *(continued)*	
	• prenatal services • labor and delivery services • postpartum services **A recommendation for doula services must come from a licensed healthcare provider.** **Prior authorization may be required and is the responsibility of your provider.**	
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this *Member Handbook* 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.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Durable medical equipment (DME) and related supplies *(continued)*	
	In Original Medicare, there is a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the purchase price is met, you can use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up. Under certain limited circumstances we will transfer ownership of the DME item to you. Visit **AetnaMedicare.com/MICHDSNP** to find network DME providers. **Prior authorization may be required and is the responsibility of your provider.**	
	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. In addition to Medicare-covered benefits, 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.

	Covered Service	What you pay
	Emergency care *(continued)*	
	$250,000 annual maximum benefit for worldwide emergency, emergency ambulance, and urgently needed care. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.	
	Fall prevention You get a $100 annual benefit amount (allowance) to purchase approved home and bathroom safety products. These products can help you manage physical impairments and improve your ability to move around your home. To learn more about this benefit and order approved products, use the CVS Flex Benefits™ app or visit **CVS.com/benefits**. You can also call **1-866-799-3832** (**TTY:** 711) Monday through Friday, 8 AM - 8 PM local time. **Note:** • You cannot place more than 3 orders per year. • You cannot pay out-of-pocket if your purchase is above your benefit amount. • Products can only be purchased using the CVS Flex Benefits™ app, online or by phone. • Some products available online may occasionally be out of stock. If this occurs, you may choose alternate eligible items or wait until the item becomes available again. If you decide to wait and your benefit expiration date is approaching, be sure to use your funds. Unused balance due to out-of-stock products will not roll over. Plan your allowance carefully, as exceptions will not be granted once the benefit period has ended. • Products are not covered by any type of warranty after purchase. If you have any issue with products ordered or received, please contact the vendor, CVS Flex Benefits. You have 30 days to report defective or damaged products ordered online. • Due to the personal nature of the products, no returns or exchanges are possible. • Aetna is not responsible for malfunctioning items.	$0

	Covered Service	What you pay
	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 **Prior authorization may be required for genetic counseling and testing. Prior authorization is the responsibility of your provider.**	$0
	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.	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Fitness: Basic SilverSneakers® membership *(continued)*	
	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.	
	Group prenatal care services The plan will pay for group prenatal care services if you have a low-risk pregnancy that doesn't require individual monitoring. You'll be educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception. Group sessions are facilitated by a trained healthcare provider and include others in similar stages of pregnancy. The plan may cover up to 12 total in-person group sessions per pregnancy in addition to the required individual professional maternity visit, if: • The group session is in addition to but doesn't replace the individual prenatal physical assessment visit • The group session is at least 60 minutes • The time spent in the group session is documented One of the 12 group sessions may relate to the postpartum professional visit.	$0

	Covered Service	What you pay
	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 **1-855-493-7019** (**TTY:** 711). The registered nurse staff cannot diagnose, prescribe or give medical advice. If you need urgent or emergency care, call 911 and/or your doctor immediately. While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics. **Health education:** You can meet with a certified health educator or other qualified health professional to learn about health and wellness topics like: diabetes management, nutrition counseling, asthma education, and more. You have the option to meet one-on-one, in a group, or virtually. Ask your provider for information on how these services may help you.	$0
	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. For adults aged 21 and older, the plan pays for evaluation and fitting for a hearing aid twice per year and pays for a hearing aid once every five years. Referral and authorization are required. In addition to Medicare-covered benefits, we also offer: • Routine hearing exams: one exam every year • Hearing aid fitting/evaluation: one hearing aid fitting/ evaluation every year • Hearing aids: You get an annual benefit amount (allowance) up to a maximum amount of $1,500 per ear, every year. This benefit amount can only be used to purchase hearing aids through an authorized NationsHearing network provider.	There is no coinsurance, copayment, or deductible for Medicare-covered hearing services. $0 copay for each non-Medicare covered hearing exam. $0 copay for each additional hearing aid fitting/evaluation. Hearing aids: $0 copay per ear, per year (two hearing aids every year).
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Hearing services *(continued)*	
	Routine hearing exam and hearing aids: We have teamed up with NationsHearing to provide your hearing exam and hearing aids. You must see a provider in the NationsHearing network for your hearing exam and hearing aids to be covered. Your hearing aid benefit amount can only be used to purchase hearing aids through a NationsHearing network provider. The benefit amount is applied to the hearing aids at the time of purchase. If the cost is more than the benefit amount, you pay the difference. You can schedule your hearing exam or hearing aid appointment with a NationsHearing provider by calling 1-877-225-0137 (**TTY:** 711). Representatives are available 8:00 am to 8:00 pm local time, 7 days a week, with the exception of holidays.	
	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 (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Home health agency care *(continued)*	
	• medical equipment and supplies • home health aide when provided with a nursing service **Prior authorization may be required and is the responsibility of your provider.**	
	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.	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 HIDE (HMO D-SNP). Hospice consultations are included as part of inpatient hospital care.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Hospice care *(continued)*	
	Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care When you're admitted to a hospice, you have the right to stay in our plan. **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 *Member Handbook*. **Note:** If you need non-hospice care, call your Care Coordinator and/or Member Services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Call your Care Coordinator at 1-855-676-5772 (**TTY:** 711), 8 AM to 8 PM, 7 days a week.	
	Immunizations We pay for the following services:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Immunizations *(continued)*	
	• 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 • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Member Handbook* 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 services	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Inpatient hospital care *(continued)*	
	• 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 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. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information 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**. **Prior authorization may be required and is the responsibility of your provider.**	
	Inpatient services in a psychiatric hospital We'll pay for up to 190 lifetime days of your admission to an inpatient psychiatric hospital. Once you've used all 190 lifetime days, you'll be disenrolled from the program and your services will be covered directly by Medicaid. **Prior authorization may be required and is the responsibility of your provider.**	$0

	Covered Service	What you pay
	Kidney disease services and supplies We pay for the following services: • 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 *Member Handbook*, 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. **Prior authorization may be required and is the responsibility of your provider.**	$0
	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	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Lung cancer screening with low dose computed tomography (LDCT) *(continued)*	
	screenings, the visit must meet the Medicare criteria for such visits.	
	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 up to 28 freshly prepared meals for a 14-day period. 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 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 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	$0 Part B drugs may be subject to step therapy requirements.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Medicare Part B drugs *(continued)*	
	• insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug, Leqembi® (generic lecanemab) which is given intravenously (IV). In addition to medication costs, 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. • 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
	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) This link will take you to a list of Part B drugs that may be subject to Step Therapy: **Aetna.com/PartB-Step**. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan. **Prior authorization may be required and is the responsibility of your provider.**	
	Non-emergency medical transportation The plan will cover transportation for you to travel to or from your medical appointments and the pharmacy if it is a covered service. Types of non-emergency transportation include: • wheelchair-equipped van • service car • taxicab **Transportation services (non-emergency)** Rides are provided to and from plan-approved locations including medical offices and urgent care centers. To schedule, change or cancel a ride, just give MTM Health a call at **1-855-814-1699** (**TTY:** **711**) Monday through Friday, 7 AM to 8 PM local time. Rides should be scheduled at least 48 hours (not	$0 Our authorized vendor, MTM Health, must be used for the transportation benefit.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Non-emergency medical transportation *(continued)*	
	including weekends and holidays) before your pickup time and can be canceled up to one business day before your pickup time. If you need to change a scheduled ride, this change must be requested at least 48 hours (not including weekends and holidays) before your required pickup time. A representative will schedule your ride through a transportation service (like a taxi or transport van) or rideshare service (like Uber or Lyft). **Important:** 1. Be sure to schedule a ride both to and from your destination. This will count as two one-way trips. 2. You are responsible for being ready when the driver arrives. 3. Drivers are not responsible for assisting you from home door to vehicle, or from vehicle to location door. If assistance is needed, you can have an escort (family member or caregiver) ride with you.	
	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 • 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	When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. The allowable amount is based on each person's situation and is determined when a person applies for assistance with paying a nursing facility. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month. Patient pay responsibility doesn't apply to Medicare-covered days in a nursing facility.
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Nursing facility care *(continued)*	
	• 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. • the nursing home where you were living when you enrolled in Aetna Medicare HIDE (HMO D-SNP) This service is intended to be long term custodial care and doesn't overlap with skilled nursing facility care. You must meet Michigan Medicaid Nursing Facility Level of Care standards to get this service. **Prior authorization may be required and is the responsibility of your provider.**	
	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	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Opioid treatment program (OTP) services *(continued)*	
	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) **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: • 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 **Prior authorization may be required and is the responsibility of your provider.**	$0
	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	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Outpatient hospital observation *(continued)*	
	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.** **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: • 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 **Prior authorization may be required and is the responsibility of your provider.**	$0
	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)	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Outpatient mental health care *(continued)*	
	• 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 Medicaid Specialty Behavioral Health Services are provided by regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs). This includes outpatient mental health care. Refer to **Section E** in this chapter for more information. The plan will pay for the following services, and maybe other services not listed here if they're Medicare or Medicaid benefits but aren't covered by the PIHP: • clinic services • day treatment • psychosocial rehab services **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. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
	Outpatient substance use disorder services We'll pay for outpatient substance use disorder services covered under Medicare Part B. For additional supports and services needed beyond what's covered by Medicare Part B, we'll assess your needs and make a referral to your local Pre-Paid Inpatient Health Plans (PIHP) or Community Mental Health Services Provider (CMHSP) for care and treatment. This includes for	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Outpatient substance use disorder services *(continued)*	
	outpatient substance use disorder services. Refer to **Section F** in this chapter for more information **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 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. **Prior authorization may be required and is the responsibility of your provider.**	$0

	Over-the-Counter (OTC) Wallet
	You get an Over-the-Counter (OTC) Wallet with a $229 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
		$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™.

	This benefit is continued on the next page.	

	Covered Service	What you pay
	Over-the-Counter (OTC) Wallet *(continued)*	
	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.	
	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, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. We'll pay for partial hospitalization and intensive outpatient services as covered under Medicare. Additional supports and services needed beyond what's covered by Medicare will be covered by Medicaid directly. **Prior authorization may be required and is the responsibility of your provider.**	$0

	Covered Service	What you pay
	Personal care services The plan will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs), which are tasks like bathing, eating, dressing, and toileting. This service can include instrumental activities of daily living (IADLs) but only when there's also a need for an ADL. IADLs include things like shopping, laundry, meal preparation, medication reminders, and taking you to your appointments. **Prior authorization may be required and is the responsibility of your provider.**	$0
	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 on your Member ID card 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 • 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	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Physician/provider services, including doctor's office visits *(continued)*	
	◦ 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/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	
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Physician/provider services, including doctor's office visits *(continued)*	
	• 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 **if:** ◦ you're not a new patient **and** ◦ the check-in isn't related to an office visit in the past seven days **and** ◦ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ◦ you're not a new patient **and** ◦ the evaluation isn't related to an office visit in the past seven days **and** ◦ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery **Prior authorization may be required and is the responsibility of your provider.**	
	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 In addition to Medicare-covered benefits, we also offer:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Podiatry services *(continued)*	
	• Additional (non-Medicare covered) podiatry services: up to six visits every year	
	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
	Prostate cancer screening exams For men age 50 and over, 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 • prosthetic shoes	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Prosthetic and orthotic devices and related supplies *(continued)*	
	• 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. **Prior authorization may be required and is the responsibility of your provider.**	
	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	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Sexually transmitted infections (STIs) screening and counseling *(continued)*	
	and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these 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**. 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 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: • 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)	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Skilled nursing facility (SNF) care *(continued)*	
	• a nursing facility where your spouse or domestic partner lives at the time you leave the hospital **Prior authorization may be required and is the responsibility of your provider.**	
	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). In addition to Medicare-covered benefits, we also offer: • Additional (non-Medicare covered) individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	$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.	$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
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	1. You must be diagnosed with one or more of the qualifying chronic conditions listed below.‡ 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
	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 ◦ Limb loss	
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	◦ 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 benefit will help maintain or improve your health or overall function.	
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	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/MIQualify**. You can also contact your Care Coordinator at **1-855-676-5772** (**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 $229 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. ◦ 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**).	
	This benefit is continued on the next page.	

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

	Covered Service	What you pay
	Special Supplemental Benefits for the Chronically Ill *(continued)*	
	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.	
	Special Supplemental Benefits for the Chronically Ill **Medication reminder system** **Special Supplemental Benefits** Our plan offers additional benefits to qualifying members. The information below describes eligibility criteria and the process to determine if you have a need that is not fully addressed by existing services, including long-term services and supports (LTSS). **Eligibility requirements:** You may be eligible for the medication reminder system if it is determined by care management that you meet the eligibility criteria below: • You must be actively participating in Aetna Care Management. • You have a qualifying diagnosis of age-related cognitive or functional decline with the regular use of multiple medications at one time; chronic medical conditions requiring strict medication adherence; neurological disorders including cognitive impairments; serious mental illness; or developmental disabilities. • Your Aetna Care Coordinator will perform a functional assessment to determine if you meet the criteria. **Benefit:** You may be eligible to receive a medication reminder system to help you stay on track. If you qualify, your Care Coordinator will work with you to request the system and have it shipped directly to you.	$0

	Covered Service	What you pay
	Stipend for maintenance costs of a service animal The plan will pay up to $20 per month for maintenance costs of a service animal if: • you're receiving personal care services, and • you're certified as disabled due to a specific condition defined by the Americans with Disabilities Act, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, **and** • the service animal is trained to meet your specific needs relative to your disability • Your service plan must document that the service animal will be used primarily to meet your personal care needs. **Prior authorization may be required and is the responsibility of your provider.**	$0
	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

	Covered Service	What you pay
	Targeted Case Management (TCM) Services The plan will pay for TCM services for members who have a chronic, or complex physical, or behavioral health care needs; and was a recent inmate or was involuntarily residing in a prison or county jail. TCM services assist members in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities (e.g., education and supports). **Prior authorization may be required and is the responsibility of your provider.**	$0
	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). In addition to Medicare-covered benefits, we also offer: • Urgent care (worldwide) $250,000 annual maximum benefit for worldwide emergency care, emergency ambulance, and urgently needed care. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.	$0

	Covered Service	What you pay
	Vision care Routine eye examinations are covered once every two years. The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions. The plan will pay for basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids). 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. 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. In addition to Medicare-covered benefits, we also offer: • Follow-up diabetic eye exam • Non-Medicare covered routine eye exam including refraction: one exam every year With this plan you get an annual benefit amount (allowance) of $250 every year for prescription eyewear including:	$0
	This benefit is continued on the next page.	

	Covered Service	What you pay
	Vision care *(continued)*	
	• Contact lenses • Eyeglasses including lenses and frames • Eyeglass lenses • Eyeglass frames • Upgrades (including UV protection and scratch coating) We have teamed up with VSP to provide this benefit. You must visit a VSP provider to use your benefit amount. If you choose eyewear that costs more than your benefit amount, you'll just need to pay the difference. To find a provider, you can search the online provider directory at **vsp.com/eye-doctor** or call the number on your member ID card.	
	"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 the phone number on your Member ID card to speak to Member Services or your Care Coordinator.	$0
	Home and Community-Based Services (HCBS) Waiver that our plan pays for	**What you pay**
	Adaptive medical equipment and supplies The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include:	$0
	This benefit is continued on the next page.	

	Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
	Adaptive medical equipment and supplies *(continued)*	
	• shower chairs/benches • lift chairs • raised toilet seats • reachers • jar openers • transfer seats • bath lifts/room lifts • swivel discs • bath aids such as long handle scrubbers • telephone aids • automated/telephone or watches that assist with medication reminders • button hooks or zipper pulls • modified eating utensils • modified oral hygiene aids • modified grooming tools • heating pads • sharps containers • exercise items and other therapy items • voice output blood pressure monitor • nutritional supplements such as Ensure **Prior authorization may be required and is the responsibility of your provider.**	
	Adult day program The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: • provides personal attention, **and** • promotes social, physical and emotional well-being **Prior authorization may be required and is the responsibility of your provider.**	$0
	Assistive technology The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include:	$0
	This benefit is continued on the next page.	

	Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
	Assistive technology *(continued)*	
	• van lifts • hand controls • computerized voice system • communication boards • voice activated door locks • power door mechanisms • specialized alarm or intercom • assistive dialing device **Prior authorization may be required and is the responsibility of your provider.**	
	Chore services The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include: • heavy household chores (washing floors, windows, and walls) • tacking loose rugs and tiles • moving heavy items and furniture • mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Environmental modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include: • installing ramps and grab bars • widening of doorways • modifying bathroom facilities • installing specialized electric systems that are necessary to accommodate medical equipment and supplies	$0
	This benefit is continued on the next page.	

	Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
	Environmental modifications *(continued)*	
	Prior authorization may be required and is the responsibility of your provider.	
	Expanded community living supports To get this service, you **must** have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Fiscal intermediary services The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community-based services authorized in your plan of care. You have the authority to hire the caregiver of your choice. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Home delivered meals The plan covers up to two prepared meals per day brought to your home if you qualify. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Non-medical transportation The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify. **Transportation services (non-emergency)**	$0 Our authorized vendor, MTM Health, must be used for the transportation benefit.
	This benefit is continued on the next page.	

	Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
	Non-medical transportation *(continued)*	
	Rides are provided to and from plan-approved locations including medical offices and urgent care centers. To schedule, change or cancel a ride, just give MTM Health a call at **1-855-814-1699** (**TTY:** 711) Monday through Friday, 7 AM to 8 PM local time. Rides should be scheduled at least 48 hours (not including weekends and holidays) before your pickup time and can be canceled up to one business day before your pickup time. If you need to change a scheduled ride, this change must be requested at least 48 hours (not including weekends and holidays) before your required pickup time. A representative will schedule your ride through a transportation service (like a taxi or transport van) or rideshare service (like Uber or Lyft). **Important:** 1. Be sure to schedule a ride both to and from your destination. This will count as two one-way trips. 2. You are responsible for being ready when the driver arrives. 3. Drivers are not responsible for assisting you from home door to vehicle, or from vehicle to location door. If assistance is needed, you can have an escort (family member or caregiver) ride with you. **Prior authorization may be required and is the responsibility of your provider.**	
	Personal emergency response system The plan covers an electronic in-home device that secures help in an emergency. You may also wear a portable “help” button to allow for mobility. The system is connected to your phone and programmed to signal a response center once a “help” button is activated. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Preventive nursing services The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may get other nursing services during the nurse visit	$0
	This benefit is continued on the next page.	

	Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you pay
	Preventive nursing services *(continued)*	
	to your home. These services are not provided on a continuous basis. **Prior authorization may be required and is the responsibility of your provider.**	
	Private Duty Nursing (PDN) The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Respite Care Services You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite isn't intended to be provided on a continuous, long-term basis where it's a part of daily services that would enable an unpaid caregiver to work elsewhere full-time. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Vehicle Modifications The plan covers adaptations or alterations to a vehicle that is used to help you meet your transportation needs. **Prior authorization may be required and is the responsibility of your provider.**	$0

2027 DentaQuest Enhanced Wrap MI
Dental Schedule of Benefits

Our plan partners with DentaQuest Dental to provide your dental benefits. Please note that some services require clinical review for preauthorization prior to treatment. These services are clinically reviewed to determine if they are indicated and appropriate based on industry standards, and that they meet DentaQuest's Clinical Criteria and Guidelines. Any treatment which, in the opinion of DentaQuest's Dental Director, is not necessary or does not meet plan's criteria will not be covered. If the prior authorization is denied, the service will not be covered, and you will be responsible for all associated costs. Dental procedures for cosmetic or aesthetic reasons are not covered. Coverage is limited to the services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered. To locate a network provider you may call DentaQuest Member Services at 1-844-870-3976 (**TTY:** 711) or search the DentaQuest online provider directory at **https://www.dentaquest.com/en/find-a-dentist**. It is recommended that you work with your in network dentist to check benefit coverage prior to obtaining dental services. If you choose to use a provider outside of the network, the services you receive will not be covered. Additional Limitations and Exclusions are listed below the Schedule of Benefits.

Maximum Annual Benefit $2,000
$0 Deductible
Services in Bold with an asterisk apply toward Annual Maximum

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0120	periodic oral evaluation - established patient	$0	No	One of (D0120, D0145) per 6 Month(s) Per patient.	Not Applicable	Medicaid covered
D0140	limited oral evaluation - problem focused	$0	No	Two of (D0140) per 1 Month(s) Per patient.	Not Applicable	Medicaid covered
D0145*	oral evaluation for a patient under three years of age and counseling with primary caregiver	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0150	comprehensive oral evaluation - new or established patient	$0	No	One of (D0120, D0150) per 6 Month(s) Per patient. One of (D0150) per 36 Month(s) Per patient.	Not Applicable	Medicaid covered
D0160*	detailed and extensive oral evaluation – problem focused, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0170*	re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0171*	re-evaluation – post-operative office visit	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0180	comprehensive periodontal evaluation - new or established patient	$0	No	One of (D0180) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0190*	screening of a patient	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0191	assessment of a patient	$0	No	One of (D0191) per 6 Month(s) Per patient.	Not Applicable	Medicaid covered
D0210	intraoral – comprehensive series of radiographic images	$0	No	One of (D0210, D0330, D0372, D0387) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D0220	intraoral - periapical first radiographic image	$0	No		Not Applicable	Medicaid covered
D0230	intraoral - periapical each additional radiographic image	$0	No		Not Applicable	Medicaid covered
D0240*	intraoral - occlusal radiographic image	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0250*	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0251*	extra-oral posterior dental radiographic image	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0270	bitewing - single radiographic image	$0	No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0272	bitewings - two radiographic images	$0	No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0273	bitewings - three radiographic images	$0	No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0274	bitewings - four radiographic images	$0	No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0277*	vertical bitewings - 7 to 8 radiographic images	$0	No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0310*	sialography	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0320*	temporomandibular joint arthrogram, including injection	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0321*	other temporomandibular joint radiographic images, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0322*	tomographic survey	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0330	panoramic radiographic image	$0	No	One of (D0210, D0330, D0372, D0387) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D0340*	2D cephalometric radiographic image – acquisition, measurement and analysis	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0350*	2D oral/facial photographic image obtained intra-orally or extra-orally	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0364*	cone beam CT capture and interpretation with limited field of view – less than one whole jaw	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0365*	cone beam CT capture and interpretation with field of view of one full dental arch – mandible	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0366*	cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0367*	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0368*	cone beam CT capture and interpretation for TMJ series including two or more exposures	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0369*	maxillofacial MRI capture and interpretation	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0370*	maxillofacial ultrasound capture and interpretation	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0371*	sialoendoscopy capture and interpretation	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	$0	No	One of (D0210, D0330, D0372, D0387) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D0373	intraoral tomosynthesis – bitewing radiographic image	$0	No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0374	intraoral tomosynthesis – periapical radiographic image	$0	No		Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0380*	cone beam CT image capture with limited field of view – less than one whole jaw	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0381*	cone beam CT image capture with field of view of one full dental arch – mandible	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0382*	cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0383*	cone beam CT image capture with field of view of both jaws; with or without cranium	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0384*	cone beam CT image capture for TMJ series including two or more exposures	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0385*	maxillofacial MRI image capture	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0386*	maxillofacial ultrasound image capture	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	$0	No	One of (D0210, D0330, D0372, D0387) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	$0	No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	$0	No		Not Applicable	Medicaid covered
D0391*	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0393*	virtual treatment simulation using 3D image volume or surface scan	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0394*	digital subtraction of two or more images or image volumes of the same modality	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0395*	fusion of two or more 3D image volumes of one or more modalities	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0396*	3D printing of a 3D dental surface scan	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0411*	HbA1c in-office point of service testing	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0412*	blood glucose level test – in-office using a glucose meter	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0414*	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0415*	collection of microorganisms for culture and sensitivity	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0416*	viral culture	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0417*	collection and preparation of saliva sample for laboratory analysis	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0418*	analysis of saliva sample - laboratory	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0419*	assessment of salivary flow by measurement	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0422*	collection and preparation of genetic sample material for laboratory analysis and report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0423*	analysis of genetic sample material for susceptibility to diseases – laboratory	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0425*	caries susceptibility tests	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0431*	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0460*	pulp vitality tests	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0470*	diagnostic casts	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0472*	accession of tissue, gross examination, preparation and transmission of written report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0473*	accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0474*	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0475*	decalcification procedure	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0476*	special stains for microorganisms	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0477*	special stains, not for microorganisms	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0478*	immunohistochemical stains	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0479*	tissue in-situ hybridization, including interpretation	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0480*	accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0481*	electron microscopy	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0482*	direct immunofluorescence	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0483*	indirect immunofluorescence	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0484*	consultation on slides prepared elsewhere	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0485*	consultation, including preparation of slides from biopsy material supplied by referring source	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0486*	laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0502*	other oral pathology procedures, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0600*	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0601*	caries risk assessment and documentation, with a finding of low risk	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0602*	caries risk assessment and documentation, with a finding of moderate risk	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0603*	caries risk assessment and documentation, with a finding of high risk	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0604*	antigen testing for a public health related pathogen, including coronavirus	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0605*	antibody testing for a public health related pathogen, including coronavirus	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0701*	panoramic radiographic image – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0702*	2-D cephalometric radiographic image – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0703*	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0705*	extra-oral posterior dental radiographic image – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0706*	intraoral – occlusal radiographic image – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0707*	intraoral – periapical radiographic image – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0708*	intraoral – bitewing radiographic image – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0709*	intraoral – comprehensive series of radiographic images – image capture only	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0801*	3D intraoral surface scan – direct	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D0802*	3D dental surface scan – indirect	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0803*	3D facial surface scan – direct	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D0804*	3D facial surface scan – indirect	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1110	prophylaxis - adult	$0	No	One of (D1110) per 6 Month(s) Per patient.	Not Applicable	Medicaid covered
D1120*	prophylaxis - child	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1206*	application of medicament – topical fluoride – excluding varnish; full mouth	$0	No	One of (D1206, D1208, D1209) per 6 Month(s) Per patient.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D1208*	topical application of fluoride – excluding varnish	$0	No	One of (D1206, D1208, D1209) per 6 Month(s) Per patient.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1209*	application of caries preventive medicament – topical non-fluoride; full mouth	$0	No	One of (D1206, D1208, D1209) per 6 Month(s) Per patient.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1301*	immunization counseling	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1310*	nutritional counseling for control of dental disease	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1320*	tobacco counseling for the control and prevention of oral disease	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1321*	counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D1330*	oral hygiene instructions	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1351*	sealant - per tooth	$0	No	One of (D1351) per 36 Month(s) Per patient, Same tooth.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1353*	sealant repair – per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1354*	application of caries arresting medicament without surgical intervention – per tooth	$0	No	Four of (D1354) per Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient, Same tooth. Six of (D1354) per 1 Lifetime Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1355*	application of medicament – primary prevention, or remineralization without surgical intervention; per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D1510*	space maintainer - fixed, unilateral – per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1516*	space maintainer - fixed - bilateral, maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1517*	space maintainer - fixed - bilateral, mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1520*	space maintainer - removable, unilateral - per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1526*	space maintainer - removable - bilateral, maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1527*	space maintainer - removable - bilateral, mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D1551*	re-cement or re-bond bilateral space maintainer - maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1552*	re-cement or re-bond bilateral space maintainer - mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1553*	re-cement or re-bond unilateral space maintainer - per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1556*	removal of fixed unilateral space maintainer - per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1557*	removal of fixed bilateral space maintainer - maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D1558*	removal of fixed bilateral space maintainer - mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D1575*	distal shoe space maintainer - fixed, unilateral - per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2140	amalgam - one surface, primary or permanent	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2150	amalgam - two surfaces, primary or permanent	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered
D2160	amalgam - three surfaces, primary or permanent	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2161	amalgam - four or more surfaces, primary or permanent	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered
D2330	resin-based composite - one surface, anterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2331	resin-based composite - two surfaces, anterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered
D2332	resin-based composite - three surfaces, anterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2335	resin-based composite - four or more surfaces (anterior)	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered
D2390	resin-based composite crown – direct	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2391	resin-based composite - one surface, posterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered
D2392	resin-based composite - two surfaces, posterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2393	resin-based composite - three surfaces, posterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered
D2394	resin-based composite - four or more surfaces, posterior	$0	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient, Same tooth/ Same surface.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2410*	gold foil - one surface	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2420*	gold foil - two surfaces	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2430*	gold foil - three surfaces	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2510*	inlay - metallic - one surface	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2520*	inlay - metallic - two surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2530*	inlay - metallic - three or more surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2542*	onlay - metallic - two surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2543*	onlay - metallic - three surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2544*	onlay - metallic - four or more surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2610*	inlay - porcelain/ceramic - one surface	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2620*	inlay - porcelain/ceramic - two surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2630*	inlay - porcelain/ceramic - three or more surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2642*	onlay - porcelain/ceramic - two surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2643*	onlay - porcelain/ceramic - three surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2644*	onlay - porcelain/ceramic - four or more surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2650*	inlay - resin-based composite - one surface	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2651*	inlay - resin-based composite - two surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2652*	inlay - resin-based composite - three or more surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2662*	onlay - resin-based composite - two surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2663*	onlay - resin-based composite - three surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2664*	onlay - resin-based composite - four or more surfaces	$0	No	D2510-D2664 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2710	crown - resin-based composite (indirect)	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2712	crown - ¾ resin-based composite (indirect)	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2720*	crown - resin with high noble metal	$0	No	D2720-D2721 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2721*	crown - resin with predominantly base metal	$0	No	D2720-D2721 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2722	crown - resin with noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2740	crown - porcelain/ceramic	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2750	crown - porcelain fused to high noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2751	crown - porcelain fused to predominantly base metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2752	crown - porcelain fused to noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2753	crown - porcelain fused to titanium and titanium alloys	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2780	crown - 3/4 cast high noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2781	crown - 3/4 cast predominantly base metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2782	crown - 3/4 cast noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2783	crown - 3/4 porcelain/ceramic	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2790	crown - full cast high noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2791	crown - full cast predominantly base metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2792	crown - full cast noble metal	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered
D2794	crown - titanium and titanium alloys	$0	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient, Same tooth.	pre-operative x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2799*	interim crown – further treatment or completion of diagnosis necessary prior to final impression	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0	No	One of (D2910) per 12 Month(s) Per patient, Same tooth.	Not Applicable	Medicaid covered
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	$0	No	One of (D2915) per 12 Month(s) Per patient, Same tooth.	Not Applicable	Medicaid covered
D2920	re-cement or re-bond crown	$0	No	One of (D2920) per 12 Month(s) Per patient, Same tooth.	Not Applicable	Medicaid covered
D2921*	reattachment of tooth fragment, incisal edge or cusp	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2928*	prefabricated porcelain/ ceramic crown – permanent tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2929*	prefabricated porcelain/ ceramic crown – primary tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2930*	prefabricated stainless steel crown - primary tooth	$0	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2931*	prefabricated stainless steel crown - permanent tooth	$0	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2932*	prefabricated resin crown	$0	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2933*	prefabricated stainless steel crown with resin window	$0	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2934*	prefabricated esthetic coated stainless steel crown - primary tooth	$0	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2940*	placement of interim direct restoration	$0	No	One of (D2940) per 1 Lifetime Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2949*	restorative foundation for an indirect restoration	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2950	core buildup, including any pins when required	$0	No	One of (D2950, D2952, D2954) per 24 Month(s) Per patient, Same tooth.	Not Applicable	Medicaid covered
D2951	pin retention - per tooth, in addition to restoration	$0	No	One of (D2951) per 12 Month(s) Per patient, Same tooth.	Not Applicable	Medicaid covered
D2952*	post and core in addition to crown, indirectly fabricated	$0	No	One of (D2950, D2952, D2954) per 24 Month(s) Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2953*	each additional indirectly fabricated post - same tooth	$0	No	One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2954*	prefabricated post and core in addition to crown	$0	No	One of (D2950, D2952, D2954) per 24 Month(s) Per patient, Same tooth.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2955*	post removal	$0	No	One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2956*	removal of an indirect restoration on a natural tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2957*	each additional prefabricated post - same tooth	$0	No	One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2960*	labial veneer (resin laminate) - direct	$0	No	D2960-D2962 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2961*	labial veneer (resin laminate) - indirect	$0	No	D2960-D2962 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2962*	labial veneer (porcelain laminate) - indirect	$0	No	D2960-D2962 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2971*	additional procedures to customize a crown to fit under an existing partial denture framework	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2975*	coping	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2976*	band stabilization – per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2980*	crown repair necessitated by restorative material failure	$0	No	One per tooth per year		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2981*	inlay repair necessitated by restorative material failure	$0	No	One per tooth per year		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2982*	onlay repair necessitated by restorative material failure	$0	No	One per tooth per year		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2983*	veneer repair necessitated by restorative material failure	$0	No	One per tooth per year		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2989*	excavation of a tooth resulting in the determination of non-restorability	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2990*	resin infiltration of incipient smooth surface lesions	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D2991*	application of hydroxyapatite regeneration medicament – per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D2999	unspecified restorative procedure, by report	$0	Yes		Lab Bills	Medicaid covered
D3110*	pulp cap - direct (excluding final restoration)	$0	Yes		Lab Bills	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3120*	pulp cap - indirect (excluding final restoration)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3221*	pulpal debridement, primary and permanent teeth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D3230*	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3240*	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$0	No	One of (D3310) per 1 Lifetime Per patient, Same tooth.		Medicaid covered
D3320	endodontic therapy, premolar tooth (excluding final restoration)	$0	No	One of (D3320) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3330	endodontic therapy, molar tooth (excluding final restoration)	$0	No	One of (D3330) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3331*	treatment of root canal obstruction; non-surgical access	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D3333*	internal root repair of perforation defects	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3346	retreatment of previous root canal therapy - anterior	$0	No	One of (D3346) per 1 Lifetime Per patient, Same tooth.		Medicaid covered
D3347	retreatment of previous root canal therapy - premolar	$0	No	One of (D3347) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3348	retreatment of previous root canal therapy - molar	$0	No	One of (D3348) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3351*	apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3352*	apexification/recalcification – interim medication replacement	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3353*	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D3355*	pulpal regeneration - initial visit	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3356*	pulpal regeneration - interim medication replacement	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3357*	pulpal regeneration - completion of treatment	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3410	apicoectomy - anterior	$0	No	One of (D3410) per 1 Lifetime Per patient, Same tooth.		Medicaid covered
D3421	apicoectomy - premolar (first root)	$0	No	One of (D3421) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3425	apicoectomy - molar (first root)	$0	No	One of (D3425) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3426	apicoectomy (each additional root)	$0	No	One of (D3426) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D3428*	bone graft in conjunction with periradicular surgery – per tooth, single site	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3429*	bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3430	retrograde filling - per root	$0	No	One of (D3430) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D3431*	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3432*	guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3450*	root amputation - per root	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D3470*	intentional re-implantation (including necessary splinting)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3471*	surgical repair of root resorption - anterior	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3472*	surgical repair of root resorption – premolar	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3473*	surgical repair of root resorption – molar	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3501*	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3502*	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D3503*	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3910*	surgical procedure for isolation of tooth with rubber dam	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3920*	hemisection (including any root removal), not including root canal therapy	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3921*	decoronation or submergence of an erupted tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3950*	canal preparation and fitting of preformed dowel or post	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D3999	unspecified endodontic procedure, by report	$0	Yes		narrative of medical necessity	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4210*	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4211*	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$0	Yes		narrative of medical necessity	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4212*	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4230*	anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4231*	anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4240*	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4241*	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4245*	apically positioned flap	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4249*	clinical crown lengthening – hard tissue	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4260*	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4261*	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4263*	bone replacement graft – retained natural tooth – first site in quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4264*	bone replacement graft – retained natural tooth – each additional site in quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4265*	biologic materials to aid in soft and osseous tissue regeneration, per site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4266*	guided tissue regeneration, natural teeth – resorbable barrier, per site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4267*	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4268*	surgical revision procedure, per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4270*	pedicle soft tissue graft procedure	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4273*	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4274*	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4275*	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4276*	combined connective tissue and pedicle graft, per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4277*	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4278*	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4283*	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4285*	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4286*	removal of non-resorbable barrier	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4322*	splint – intra-coronal; natural teeth or prosthetic crowns	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4323*	splint – extra-coronal; natural teeth or prosthetic crowns	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4324*	repair of fixed splint – extra-coronal; natural teeth or prosthetic crowns	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4325*	repair of fixed splint – extra-coronal; natural teeth or prosthetic crowns	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4326*	removal of fixed splint – intra-coronal; natural teeth or prosthetic crowns does not include repair of resulting defects	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4327*	removal of fixed splint – extra-coronal; natural teeth or prosthetic crowns	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$0	No	One of (D4341, D4342) per 24 Month(s) Per patient, Same quadrant.	Full mouth xrays & perio charting	Medicaid covered
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$0	No	One of (D4341, D4342) per 24 Month(s) Per patient, Same quadrant.	Full mouth xrays & perio charting	Medicaid covered
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$0	Yes	One of (D4346) per 6 Month(s) Per patient.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$0	Yes	One of (D4355) per 12 Month(s) Per patient.	Not Applicable	Medicaid covered
D4381*	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4910	periodontal maintenance	$0	No	One of (D4910) per 6 Month(s) Per patient		Medicaid covered
D4920*	unscheduled dressing change (by someone other than treating dentist or their staff)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D4921*	gingival irrigation with a medicinal agent – per quadrant	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5110	complete denture - maxillary	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5120	complete denture - mandibular	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5130	immediate denture - maxillary	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5140	immediate denture - mandibular	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5221	immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5222	immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.		Medicaid covered
D5224	immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.		Medicaid covered
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.		Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.		Medicaid covered
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$0	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.		Medicaid covered
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$0	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.	Not Applicable	Medicaid covered
D5282*	removable unilateral partial denture – one piece cast metal (including retentive/ clasping materials, rests, and teeth), maxillary	$0	No	D5282-D5286 1 per arch per 5 years	pre-operative x-ray(s)	Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5283*	removable unilateral partial denture – one piece cast metal (including retentive/ clasping materials, rests, and teeth), mandibular	$0	No	D5282-D5286 1 per arch per 5 years	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5284*	removable unilateral partial denture – one piece flexible base (including retentive/ clasping materials, rests, and teeth) – per quadrant	$0	No	D5282-D5286 1 per arch per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5286*	removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	$0	No	D5282-D5286 1 per arch per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5410	adjust complete denture - maxillary	$0	No	One of (D5410) per 6 Month(s) Per patient.		Medicaid covered
D5411	adjust complete denture - mandibular	$0	No	One of (D5411) per 6 Month(s) Per patient.		Medicaid covered
D5421	adjust partial denture - maxillary	$0	No	One of (D5421) per 6 Month(s) Per patient.	Not Applicable	Medicaid covered
D5422	adjust partial denture - mandibular	$0	No	One of (D5422) per 6 Month(s) Per patient.	Not Applicable	Medicaid covered
D5511	repair complete denture base, mandibular	$0	No		Not Applicable	Medicaid covered
D5512	repair complete denture base, maxillary	$0	No		Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5520	replace missing or broken teeth – complete denture – per tooth	$0	No		Not Applicable	Medicaid covered
D5521*	replace all teeth on complete denture – maxillary	$0	No	One of (D5110, D5130, D5521) per 60 Month(s) Per patient.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5522*	replace all teeth on complete denture – mandibular	$0	No	One of (D5120, D5140, D5522) per 60 Month(s) Per patient.	Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5611	repair resin partial denture base, mandibular	$0	No		Not Applicable	Medicaid covered
D5612	repair resin partial denture base, maxillary	$0	No		Not Applicable	Medicaid covered
D5621	repair cast partial framework, mandibular	$0	No		Not Applicable	Medicaid covered
D5622	repair cast partial framework, maxillary	$0	No		Not Applicable	Medicaid covered
D5630	repair or replace broken retentive clasping materials – per tooth	$0	No		Not Applicable	Medicaid covered
D5640	replace missing or broken teeth – partial denture – per tooth	$0	No		Not Applicable	Medicaid covered
D5650	add tooth to existing partial denture – per tooth	$0	No		Not Applicable	Medicaid covered
D5660	add clasp to existing partial denture - per tooth	$0	No		Not Applicable	Medicaid covered
D5670*	replace all teeth and acrylic on cast metal framework (maxillary)	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5671*	replace all teeth and acrylic on cast metal framework (mandibular)	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5710	rebase complete maxillary denture	$0	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient, Same Arch.		Medicaid covered
D5711	rebase complete mandibular denture	$0	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient, Same Arch.		Medicaid covered
D5720	rebase maxillary partial denture	$0	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5721	rebase mandibular partial denture	$0	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5725	rebase hybrid prosthesis	$0	No	One of (D5725) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5730	reline complete maxillary denture (direct)	$0	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5731	reline complete mandibular denture (direct)	$0	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5740	reline maxillary partial denture (direct)	$0	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5741	reline mandibular partial denture (direct)	$0	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5750	reline complete maxillary denture (indirect)	$0	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5751	reline complete mandibular denture (indirect)	$0	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5760	reline maxillary partial denture (indirect)	$0	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5761	reline mandibular partial denture (indirect)	$0	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5765	soft liner for complete or partial removable denture – indirect	$0	No	One of (D5765) per 24 Month(s) Per patient, Same Arch.	Not Applicable	Medicaid covered
D5810*	interim complete denture (maxillary)	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5811*	interim complete denture (mandibular)	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5820	interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$0	No			Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5821*	interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5850*	tissue conditioning, maxillary	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5851*	tissue conditioning, mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5859*	Placement of Semi-Precision Abutment-Natural Tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5862*	precision attachment, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5863*	overdenture – complete maxillary - natural tooth borne	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5864*	overdenture – partial maxillary - natural tooth borne	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5865*	overdenture – complete mandibular - natural tooth borne	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5866*	overdenture – partial mandibular - natural tooth borne	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5867*	replacement of replaceable part of semi-precision or precision attachment of natural tooth borne prosthesis, per attachment	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5876*	add metal substructure to acrylic complete denture - per arch	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5877	duplication of complete denture - maxillary	$0	No			Medicaid covered
D5878	duplication of complete denture - mandibular	$0	No			Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D5991*	vesiculobullous disease medicament carrier	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5992*	adjust maxillofacial prosthetic appliance, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5993*	cleaning of a maxillofacial prosthesis (extra or intra-oral), by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5995*	medicament carrier with peripheral seal – laboratory processed – maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5996*	medicament carrier with peripheral seal – laboratory processed – mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D5998*	Repair Maxillofacial Prosthesis, By Report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6205*	pontic - indirect resin based composite	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6210*	pontic - cast high noble metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6211*	pontic - cast predominantly base metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6212*	pontic - cast noble metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6214*	pontic - titanium and titanium alloys	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6240*	pontic - porcelain fused to high noble metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6241*	pontic - porcelain fused to predominantly base metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6242*	pontic - porcelain fused to noble metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6243*	pontic - porcelain fused to titanium and titanium alloys	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6245*	pontic - porcelain/ceramic	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6250*	pontic - resin with high noble metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6251*	pontic - resin with predominantly base metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6252*	pontic - resin with noble metal	$0	No	D6205 - D6252 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6253*	interim pontic - further treatment or completion of diagnosis necessary prior to final impression	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6545*	retainer - cast metal for resin bonded fixed prosthesis	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6548*	retainer - porcelain/ceramic for resin bonded fixed prosthesis	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6549*	retainer – resin bonded fixed prosthesis	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6600*	retainer inlay - porcelain/ ceramic, two surfaces	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6601*	retainer inlay - porcelain/ ceramic, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6602*	retainer inlay - cast high noble metal, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6603*	retainer inlay - cast high noble metal, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6604*	retainer inlay - cast predominantly base metal, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6605*	retainer inlay - cast predominantly base metal, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6606*	retainer inlay - cast noble metal, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6607*	retainer inlay - cast noble metal, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6608*	retainer onlay - porcelain/ ceramic, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6609*	retainer onlay - porcelain/ ceramic, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6610*	retainer onlay - cast high noble metal, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6611*	retainer onlay - cast high noble metal, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6612*	retainer onlay - cast predominantly base metal, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6613*	retainer onlay - cast predominantly base metal, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6614*	retainer onlay - cast noble metal, two surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6615*	retainer onlay - cast noble metal, three or more surfaces	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6624*	retainer inlay - titanium	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6634*	retainer onlay - titanium	$0	No	D6601 -D6634 One per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6710*	retainer crown - indirect resin based composite	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6720*	retainer crown - resin with high noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6721*	retainer crown - resin with predominantly base metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6722*	retainer crown - resin with noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6740*	retainer crown - porcelain/ ceramic	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6750*	retainer crown - porcelain fused to high noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6751*	retainer crown - porcelain fused to predominantly base metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6752*	retainer crown - porcelain fused to noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6753*	retainer crown - porcelain fused to titanium and titanium alloys	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6780*	retainer crown - 3/4 cast high noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6781*	retainer crown - 3/4 cast predominantly base metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6782*	retainer crown - 3/4 cast noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6783*	retainer crown - 3/4 porcelain/ ceramic	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6784*	retainer crown ¾ - titanium and titanium alloys	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6790*	retainer crown - full cast high noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6791*	retainer crown - full cast predominantly base metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6792*	retainer crown - full cast noble metal	$0	No	One D6545, D6548 or D6720-D6792 per tooth per 5 years		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6793*	interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6794*	retainer crown - titanium and titanium alloys	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D6920*	connector bar	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6930	re-cement or re-bond fixed partial denture	$0	No			Medicaid covered
D6940*	stress breaker	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6950*	precision attachment	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6980*	fixed partial denture repair necessitated by restorative material failure	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D6985*	pediatric partial denture, fixed	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7111	extraction, coronal remnants – primary tooth	$0	No	One of (D7111) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7140	extraction, erupted tooth or exposed root (elevation and/ or forceps removal)	$0	No	One of (D7140) per Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$0	No	One of (D7210) per Lifetime Per patient, Same tooth.		Medicaid covered
D7220	removal of impacted tooth - soft tissue	$0	No	One of (D7220) per Lifetime Per patient, Same tooth.		Medicaid covered
D7230	removal of impacted tooth - partially bony	$0	No	One of (D7230) per Lifetime Per patient, Same tooth.		Medicaid covered
D7240	removal of impacted tooth - completely bony	$0	No	One of (D7240) per Lifetime Per patient, Same tooth.		Medicaid covered
D7241*	removal of impacted tooth - completely bony, with unusual surgical complications	$0	No	One of (D7241) per 1 Lifetime Per patient, Same tooth.		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7250	removal of residual tooth roots (cutting procedure)	$0	No	One of (D7250) per Lifetime Per patient, Same tooth.		Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7251*	coronectomy – intentional partial tooth removal, impacted teeth only	$0	No	One per tooth per lifetime		Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7260	oroantral fistula closure	$0	No	One of (D7260) per Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D7261	primary closure of a sinus perforation	$0	No	One of (D7261) per 1 Lifetime Per patient, Same quadrant.	Not Applicable	Medicaid covered
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$0	No	One of (D7270) per 1 Lifetime Per patient, Same tooth.	Not Applicable	Medicaid covered
D7272*	tooth transplantation (includes re-implantation from one site to another and splinting and/ or stabilization)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7280*	exposure of an unerupted tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7282*	mobilization of erupted or malpositioned tooth to aid eruption	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7283*	placement of device to facilitate eruption of impacted tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7290*	surgical repositioning of teeth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7291*	transseptal fiberotomy/supra crestal fiberotomy, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7292*	primary closure of a sinus perforation	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7293*	placement of temporary anchorage device requiring flap	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7294*	placement of temporary anchorage device without flap	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7298*	removal of temporary anchorage device [screw retained plate], requiring flap	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7299*	removal of temporary anchorage device, requiring flap	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7300*	removal of temporary anchorage device without flap	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0	No	One of (D7310) per Lifetime Per patient, Same tooth.	Pre and post-operative x-ray(s)	Medicaid covered
D7311*	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0	Yes	One of (D7320) per Lifetime Per patient, Same tooth.	Pre and post-operative x-ray(s)	Medicaid covered
D7321*	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7340*	vestibuloplasty - ridge extension (secondary epithelialization)	$0	Yes			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7350*	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7471	removal of lateral exostosis (maxilla or mandible)	$0	No	One of (D7471) per 1 Lifetime Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	Medicaid covered
D7472	removal of torus palatinus	$0	No	One of (D7472) per 1 Lifetime Per patient.	Photograph	Medicaid covered
D7473	removal of torus mandibularis	$0	Yes	One of (D7473) per 1 Lifetime Per patient, Same quadrant.	Photograph	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7485	reduction of osseous tuberosity	$0	Yes	One of (D7485) per 1 Lifetime Per patient, Same quadrant.	Photograph	Medicaid covered
D7510	incision and drainage of abscess - intraoral soft tissue	$0	Yes		narr. of med. necessity, pre-op x-ray(s)	Medicaid covered
D7921*	collection and application of autologous blood concentrate product	$0	Yes			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7922*	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$0	Yes			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7939*	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7953*	bone replacement graft for ridge preservation - per site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7956*	guided tissue regeneration, edentulous area – resorbable barrier, per site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7957*	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7961*	buccal / labial frenectomy (frenulectomy)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7962*	lingual frenectomy (frenulectomy)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7963*	frenuloplasty	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7970	excision of hyperplastic tissue - per arch	$0	No	One of (D7970) per 24 Month(s) Per patient, Same Arch.	narr. of med. necessity, pre-op x-ray(s)	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D7971	excision of pericoronal gingiva	$0	No	One of (D7971) per 24 Month(s) Per patient.	Not Applicable	Medicaid covered
D7972	surgical reduction of fibrous tuberosity	$0	Yes	One of (D7972) per 24 Month(s) Per patient.	narrative of medical necessity	Medicaid covered
D7979*	non – surgical sialolithotomy	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D7998*	intraoral placement of a fixation device not in conjunction with a fracture	$0	Yes			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9110*	palliative treatment of dental pain – per visit	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9120*	fixed partial denture sectioning	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9130*	temporomandibular joint dysfunction – non-invasive physical therapies – each 15 minute increment, or portion thereof	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9210*	local anesthesia not in conjunction with operative or surgical procedures	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9211*	regional block anesthesia	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9212*	trigeminal division block anesthesia	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9215*	local anesthesia in conjunction with operative or surgical procedures	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9219*	evaluation for moderate sedation, deep sedation or general anesthesia	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	$0	No	One of (D9222, D9239) per Day(s) Per patient.	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	$0	No	Three of (D9223) per Day(s) Per patient.	Not Applicable	Medicaid covered
D9230*	administration of nitrous oxide	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9239	administration of moderate sedation – intravenous - first 15 minute increment, or any portion thereof	$0	No	One of (D9222, D9239) per Day(s) Per patient.	Not Applicable	Medicaid covered
D9243	administration of moderate sedation – intravenous - each subsequent 15 minute increment, or any portion thereof	$0	No	Three of (D9243) per Day(s) Per patient.	Not Applicable	Medicaid covered
D9244	in-office administration of minimal sedation – single drug – enteral	$0	No	One of (D9244, D9245, D9246) per date of service, per patient. Not allowed with D9222, D9223, D9224, D9225, D9239, D9243	Not Applicable	Medicaid covered

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9245	administration of moderate sedation – enteral	$0	No	One of (D9244, D9245, D9246,) per date of service, per patient. Not allowed with D9222, D9223, D9224, D9225, D9239, D9243	Not Applicable	Medicaid covered
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	$0	No	One of (D9246,) per date of service, per patient.	Not Applicable	Medicaid covered
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	$0	No		Not Applicable	Medicaid covered
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	No			Medicaid covered
D9311*	consultation with a medical health care professional	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9410*	house/extended care facility call	$0	No		Not Applicable	Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9420	hospital or ambulatory surgical center call	$0	No	One of (D9420) per 24 Month(s) Per patient.	Not Applicable	Medicaid covered
D9430*	office visit for observation (during regularly scheduled hours) - no other services performed	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9440*	office visit - after regularly scheduled hours	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9450*	case presentation, subsequent to detailed and extensive treatment planning	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9610*	therapeutic parenteral drug, single administration	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9612*	therapeutic parenteral drugs, two or more administrations, different medications	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9613*	infiltration of sustained release therapeutic drug, per quadrant	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9630*	drugs or medicaments dispensed in the office for home use	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9910*	application of desensitizing medicament – per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9911*	application of desensitizing resin for cervical and/or root surface, per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9920*	behavior management, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9930*	treatment of complications (post-surgical) - unusual circumstances, by report	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9932*	cleaning and inspection of removable complete denture, maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9933*	cleaning and inspection of removable complete denture, mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9934*	cleaning and inspection of removable partial denture, maxillary	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9935*	cleaning and inspection of removable partial denture, mandibular	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9941*	fabrication of athletic mouthguard	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9942*	repair and/or reline of occlusal guard	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9943*	occlusal guard adjustment	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9944*	occlusal guard – hard appliance, full arch	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9945*	occlusal guard – soft appliance, full arch	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9946*	occlusal guard – hard appliance, partial arch	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9947*	custom sleep apnea appliance fabrication and placement	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9948*	adjustment of custom sleep apnea appliance	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9949*	repair of custom sleep apnea appliance	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9950*	occlusion analysis - mounted case	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9951*	occlusal adjustment - limited	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9952*	occlusal adjustment - complete	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9953*	reline custom sleep apnea appliance (indirect)	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9954*	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9955*	oral appliance therapy (OAT) titration visit	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9970*	enamel microabrasion	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9971*	odontoplasty - per tooth	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9992*	dental case management care coordination	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9993*	dental case management motivational interviewing	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9994*	dental case management patient education to improve oral health literacy	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount

CDT Code	Procedure Code Description	Member Pays	Pre-Auth Required	Frequency	Documentation Required	Service Coverage Type
D9995*	teledentistry – synchronous; real-time encounter	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9996*	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9997*	dental case management - patients with special health care needs	$0	No			Medicare Supplemental Dental Benefit applies toward annual maximum amount
D9998*	Dental Case Management-pediatric-to-adult transition services, patients with special healthcare needs	$0	No	Once per lifetime		Medicare Supplemental Dental Benefit applies toward annual maximum amount

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

Limitations & Exclusions

1. Coverage is limited to the services and service frequencies listed in the Schedule of Benefits. If a service is not listed, it is not covered.

2. Any dental services received outside of the U.S. or U.S. territories are not covered under the supplemental dental benefit.
3. Fees related to missed appointments, preparing or copying dental reports, duplication of x rays, itemized bills or claim forms are not covered.
4. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to you by any municipality, county, or other political subdivision is not covered.
5. Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
6. Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.
7. Orthodontic and all orthodontic related services are not covered
8. Implants and all implant related services are not covered
9. Maxillofacial prosthetics are not covered
10. Dental services performed for cosmetic and/or aesthetic reasons are not covered
11. Tooth bleaching and/or enamel microabrasion services are not covered
12. Unspecified services by report (Dental codes: D##99) are not covered
13. Dental services related to temporomandibular joint syndrome (TMJ) are not covered, unless the related dental code is listed in the schedule of benefits
14. Elective services are not covered
15. General anesthesia or conscious sedation is not a covered service unless it is based on clinical review of documentation provided and administered by a dentist or health care practitioner in conjunction with covered oral surgical procedures, periodontal and osseous surgical procedures, or periarticular surgical procedures for covered services.
16. Altering vertical dimension of teeth, or restoration/maintenance of occlusion including bite registration or bite analysis are not covered.
17. Splinting teeth, including multiple abutments, or any services to stabilize periodontally weakened teeth are not covered.
18. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction are not covered.
19. Plan frequency limitations will still apply when there is a replacement of a device or appliance that is lost, missing, stolen, or damaged due to abuse, misuse or neglect.
20. Dental procedures are only covered when performed by a dentist licensed in the US or any US territory.
21. Periodontal maintenance is not covered unless there is a history of scaling and root planing or surgical periodontal therapy.
22. Denture adjustments performed within 6 months of denture placement/installation, reline, or rebase are not covered.
23. Denture reline and rebase, if listed as covered in your schedule of benefits, performed within 6 months following the placement of a complete or immediate denture are not covered.
24. Tissue conditioning performed within 6 months of denture placement, reline, or rebase are not covered.
25. For covered dental procedures listed in your schedule of benefits, the treatment date for billing purposes is defined by completion of specific procedures.
    For removable dentures (complete and partial), this is the delivery date. For inlays, onlays, crowns, veneers and bridges, it's the date of final cementation. For root canals, it's the date the final fill is placed.
26. Procedures that are considered experimental, investigational or unproven are not covered. This includes

pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics.
27. If this policy is terminated or the covered dental services for this plan change, this plan will not cover ongoing care or treatment. This includes all multi-appointment procedures.
28. Services and supplies provided in connection with treatment or care that is not covered under the plan are not covered.

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

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

Medical necessity is determined using criteria that are:

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

E. Benefits covered outside of our plan

We don't cover Medicaid Specialty Behavioral Health Services, but they're available through regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs).

If you're receiving services through the PIHP, please refer to the separate PIHP Member Handbook for more information and work with your Care Coordinator to get services provided through the PIHP.

F. Benefits not covered by our plan, Medicare, or Michigan Medicaid

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 *Member Handbook*) 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 *Member Handbook*.

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 Michigan Medicaid 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 *Member Handbook* 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
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- 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 - our plan provides some additional coverage for routine chiropractic care as described 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. However, the plan will pay for glasses after cataract 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. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost sharing amounts.

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 Michigan Medicaid. **Chapter 6** of this *Member Handbook* tells what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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 *Member Handbook*.
- 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

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 or any similar Medicaid 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.

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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 or your care coordinator.

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 our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

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, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **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 *Member Handbook.*
- If you need help getting a prescription filled, contact your care coordinator or 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, you can contact your care coordinator or 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 or your care coordinator.

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 or your care coordinator.

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 *Drug List*.

Our plan's mail-order service allows you to order up to a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail
To get order forms and information about filling your prescriptions by mail, visit our website (**AetnaMedicare.com/MICHDSNP**) 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 get a prescription automatically by mail that you don't want, and you weren't contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

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

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy 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 you're billed and 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. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care coordinator or 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 your care coordinator or 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 instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

To learn more about this, refer to **Chapter 7** of this *Member Handbook*.

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 Michigan Medicaid.

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:

- Check the most recent *Drug List* we provided electronically.
- Visit our plan's website at **AetnaMedicare.com/MICHDSNP**. The *Drug List* on our website is always the most current one.
- Call your care coordinator or 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**. With this tool you can 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 your care coordinator or 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 *Member Handbook* 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 Michigan Medicaid 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 Michigan Medicaid 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
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for the treatment of anorexia or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. Drug List cost–sharing tiers

Every drug on our *Drug List* is in one of 5 tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

To find out which cost-sharing tier your drug is in, look for the drug on our *Drug List*.

Chapter 6 of your *Member Handbook* tells the amount you pay for drugs on each tier.

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 *Member Handbook*.

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.

- Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

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/MichDSNP-pharmacy** 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/MichDSNP-pharmacy 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/MICHDSNP. 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 *Member Handbook*.

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.
- The drug is covered, but in a cost-sharing tier that makes your cost more expensive than you think it should be.

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

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.

For Michigan Medicaid drugs:

You're new to the plan.

We'll cover a supply of your Michigan Medicaid drug for up to 90 calendar days after enrollment and won't terminate it at the end of the 90 calendar days without advance notice to you and a transition to another drug, if needed.

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 *Member Handbook*.

If you need help asking for an exception, contact your care coordinator or 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 (PA) 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/MICHDSNP** **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, but your cost for the new drug will stay the same or will be lower.
  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 *Member Handbook* 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 *Member Handbook*.

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, increase what you pay for the drug, or limit its use, then the change doesn't affect your use of the drug or what you pay for 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.

To learn more about drug coverage and what you pay, refer to **Chapter 6**.

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 *Member Handbook* 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 or your care coordinator.

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may include:

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

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific 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. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to 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 *Member Handbook*.)

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 Michigan 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 Michigan Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you’re eligible for Michigan Medicaid, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the "LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

> **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 *Member Handbook*.

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
    - which of the 5 cost-sharing tiers each drug is in
    - 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/MICHDSNP.
- **Chapter 5** of this *Member Handbook*.
  - 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 coordinator 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 *Member Handbook* for more information about network pharmacies.

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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, such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. 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 you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments made 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.

- **Lower cost alternatives.** When applicable, information about other available drugs with lower cost-sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- 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 Michigan Medicaid. 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 our share of the cost of 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 our share of the cost of a drug, refer to **Chapter 7** of this *Member Handbook*.

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 an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

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 HIDE (HMO D-SNP) Member Services. You can also find answers to many questions on our website: AetnaMedicare.com/MICHDSNP.

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 HIDE (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.
- Michigan you can report fraud by calling toll free at 855-MI-FRAUD (643-7283) Monday - Friday, 8 am to

5 pm. You can also submit an online complaint at www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/report-medicaid-fraud-and-abuse and you may find information on our website at www.michigan.gov/mdhhs/inside-mdhhs/office-of-inspector-general/contact-us, or you can write to the inspector general at Office of Inspector General PO Box 30062 Lansing, MI 48909.

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. Drug Payment Stages for Medicare Part D Drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on your level of Extra Help and which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2027. You begin this stage when you've paid a certain amount of out-of-pocket costs.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost sharing tier the drug is in and where you get it.

Cost-sharing tiers are groups of drugs with the same copay. Every drug in our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can refer to our *Drug List*.

- **Tier 1: Preferred Generic -** Many common lower cost generic drugs.
- **Tier 2: Generic -** Higher cost generic drugs.
- **Tier 3: Preferred Brand -** Many common brand name drugs and some higher cost generic drugs.
    - Depending on your level of Extra Help, you'll pay a yearly deductible of $0 - $700 on your Tier 3 drugs. You pay the full cost of your Tier 3 drugs until you've reached the yearly deductible.
- **Tier 4: Non-Preferred Drug -** Higher cost brand name and generic drugs for which a lower cost alternative is often available.
    - Depending on your level of Extra Help, you'll pay a yearly deductible of $0 - $700 on your Tier 4 drugs. You pay the full cost of your Tier 4 drugs until you've reached the yearly deductible.

- **Tier 5: Specialty -** High-cost brand and generic drugs meeting Medicare's definition of a specialty drug.
    - Depending on your level of Extra Help, you'll pay a yearly deductible of $0 - $700 on your Tier 5 drugs. You pay the full cost of your Tier 5 drugs until you've reached the yearly deductible.

D1. Your pharmacy choices

How much you pay for a drug depends on if you get the drug from:

- a network retail pharmacy, **or**
- an out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.
- our plan's mail-order pharmacy

To learn more about these pharmacy choices, refer to **Chapter 5** in this *Member Handbook* and to our *Provider and Pharmacy Directory*.

D2. 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. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Member Handbook* or our plan's *Provider and Pharmacy Directory.*

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

Contact Member Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

Part D Deductible	
Yearly Deductible	**If you qualify for Extra Help from Medicare to help pay for your prescription drugs, you pay:** $0 **If you don't qualify for Extra Help from Medicare to help pay for your prescription drugs, you pay:** $700 (Tiers 3–5) During this stage, you pay: • $0 for drugs on Tier 1 (Preferred Generic) • $0 for drugs on Tier 2 (Generic) and the full cost of drugs on: • Tier 3 (Preferred Brand) • Tier 4 (Non-Preferred Drug) • Tier 5 (Specialty) until you've reached the yearly deductible.

Tier	**A network pharmacy** A one-month or up to 100-day supply	**Our plan's mail-order service** A one-month or up to 100-day supply	**A network long-term care pharmacy** A one-month or up to 31-day supply	**An out-of-network pharmacy** Up to a 10-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 1 (Preferred Generic)	$0	$0	$0	$0
Cost-Sharing Tier 2 (Generic)	$0	$0	$0	$0

Tier	**A network pharmacy** A one-month or up to 100-day supply	**Our plan's mail-order service** A one-month or up to 100-day supply	**A network long-term care pharmacy** A one-month or up to 31-day supply	**An out-of-network pharmacy** Up to a 10-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 3 (Preferred Brand)	9% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	9% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	9% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	9% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40

Tier	**A network pharmacy** A one-month or up to 100-day supply	**Our plan's mail-order service** A one-month or up to 100-day supply	**A network long-term care pharmacy** A one-month or up to 31-day supply	**An out-of-network pharmacy** Up to a 10-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 4 (Non-Preferred Drug)	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40
Insulins	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.			

Tier	**A network pharmacy** A one-month or up to 30-day supply	**Our plan's mail-order service** A one-month or up to 30-day supply	**A network long-term care pharmacy** A one-month or up to 31-day supply	**An out-of-network pharmacy** Up to a 10-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-Sharing Tier 5 (Specialty)	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40	25% *OR* Copays for drugs may vary based on the level of Extra Help you get. *For generic or brand drugs treated like generic you pay*: $0, $1.65, or $5.80 *For Brand-name drugs you pay:* $0, $5.00, or $14.40

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $2,400. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the $2,400 limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2,400 for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

In some cases, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs:

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a seven days' supply of the drug, your payment is less than $0.05 per day multiplied by seven days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug, to help you:
  - better plan when to refill your drugs
  - Coordinate refills with other drugs so you can take fewer trips to the pharmacy.

G. 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 most adult Medicare Part D vaccines at no cost to you. Refer to our plan's *Drug List* or contact Member Services for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of **the vaccine itself**.
2. The second part is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

G1. What you need to know before you get a vaccine

We recommend that you call your care coordinator or Member Services if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

G2. 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 *Member Handbook.*
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. You may have to pay a copay for Medicare Part D vaccines. 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 a copay 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 a copay 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 only have to pay a copay 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 a copay for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay our share of 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 *Member Handbook.*

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A. Asking us to pay for your 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 HIDE (HMO D-SNP) providers to bill you for these services. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of 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 more than your share of the cost, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
  - If you paid for services covered by Michigan Medicaid we can't pay you back, but the provider will. Member Services can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact your Care Coordinator or Member Services if you have any questions. If you do not know what you should've paid, or 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 your care coordinator or 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 for our share of the cost.
- Refer to **Chapter 5** of this *Member Handbook* 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 full Medicare Part D 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 for our share of the cost.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full Medicare Part D 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 *Member Handbook*).
  - 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 *Member Handbook*).
- 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 our share of the cost of 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 our share of the cost of 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 *Member Handbook*.

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 can ask your care coordinator for help.

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 or your Care Coordinator at **1-855-676-5772** (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 HIDE (HMO D-SNP)
Aetna Duals COE Member Correspondence
PO Box 982980
El Paso, TX 79998

You must send your information to us within **12 months** of the date you received the service, item, or Part B drug.

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 HIDE (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 also decide the amount of money, if any, you must pay.

- 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 our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. 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 *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of this *Member Handbook* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for our share of the cost of 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." You can also make an appeal if you don't agree with the amount we pay.

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

- 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 *Member Handbook.*

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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 **1-855-676-5772** (**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 **1-855-676-5772** (**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 HIDE (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**.
- **You may file a complaint with Michigan Medicaid by doing the following**:
  - Fill out the Beneficiary Complaint Form (BCF) online at **www.michigan.gov/mdhhs/assistance-programs/healthcare/beneficiary-support/msa-0300-online-form**. Submitting online will send an email with your BCF to the Beneficiary Support Unit.
  - Print and complete the Beneficiary Complaint Form (MSA-0300).
  - Follow the instructions on the form and then mail it to the address shown below:
    Michigan Department of Health and Human Services
    Health and Aging Services Administration
    Customer Services Division
    PO Box 30479
    Lansing, MI 48909-7979
  - If you have questions about the Beneficiary Complaint form or this process, call the Beneficiary HelpLine at **1-800-642-3195**.
- **The Michigan Office of Recipient Rights** (ORR) is a state agency that investigates allegations of

violations of rights established by the Michigan Mental Health Code.
    - If you live in Macomb county: you may file a complaint by contacting the MCCMH-ORR at **(586) 469-6528**. Our business hours are 8:30 a.m. – 5 p.m., Monday through Friday. You may also leave a message during non-business hours and staff will contact you during normal business hours.
    - You may also fill out a Recipient Rights Complaint form and either mail, fax or e-mail it.
- 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 **1-855-676-5772** (**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 **1-855-676-5772** (**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 HIDE (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**.

- Puede presentar una queja ante Medicaid de Michigan de las siguientes maneras:
  - Complete el Formulario de queja del beneficiario (BCF) en línea en **www.michigan.gov/mdhhs/assistance-programs/healthcare/beneficiary-support/msa0300-online-form**. Si lo presenta en línea, se enviará un correo electrónico con su BCF a la Unidad de Apoyo al Beneficiario.
  - Imprima y complete el Formulario de queja del beneficiario (MSA 0300).
  - Siga las instrucciones del formulario y luego envíelo por correo a la dirección que se muestra a continuación: Michigan Department of Health and Human Services
    Health and Aging Services Administration Customer Services Division PO Box 30479 Lansing, MI 48909-7979
  - Si tiene preguntas sobre el Formulario de queja del beneficiario o este proceso, llame a la línea de ayuda para beneficiarios al **1-800-642-3195**.
- **La Oficina de Derechos del Receptor** (ORR) de Michigan es una agencia estatal que investiga denuncias de violaciones de los derechos establecidos por el Código de Salud Mental de Michigan.
- Puede presentar una queja comunicándose con la ORR del Departamento de Salud Mental Comunitaria del Condado de Macomb (MCCMH) al **(586) 469-6528**. Nuestro horario de atención es de 08:30 a. m. a 05:00 p. m., de lunes a viernes.
- También puede dejar un mensaje fuera del horario de atención y el personal se comunicará con usted durante el horario comercial normal. También puede completar un formulario de queja sobre derechos del receptor y enviarlo por correo postal, fax o correo electrónico.
- 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 *Member Handbook.*
  - 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 *Member Handbook*.
- You are free to exercise all of your rights knowing that Aetna Medicare HIDE (HMO D-SNP), our network providers, Medicare, and the Michigan Department of Health and Human Services (MDHHS) will not hold it against you.
- You have the right to receive timely information about plan changes. This includes a notice of any

significant changes in the orientation materials at least 30 days before the effective date of the change.
- You, or an authorized rep, have the right to request a reassessment by the Integrated Care Team.
- You have the right to receive reasonable advance notice of any transfer to another treatment setting.
- You have a right to an assessment to identify special health care needs.
- If you have special health care needs or need LTSS services, you have the right to have direct access to specialists, as appropriate for your condition and identified needs.

Chapter 9 of this *Member Handbook* 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. Michigan Medicaid may disclose your information without your permission for purposes of treatment, payment, health care operations or when required by law to do so.

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
  - Incentive plans: Some providers may get extra payments based on how they manage patient care. These payments are called physician incentive plans. They encourage providers to help members stay healthy, avoid unneeded tests or services and keep costs down. You have the right to ask for info about these incentive plans. You might want to ask if you think these payments affect the choices your provider makes about your care. Call Member Services for more information.
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) 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 *Member Handbook*), 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
- Our utilization management (UM) program, which ensures you get the right care in the right setting when you need it. UM staff can help you and your doctors make decisions about your health care. When we make decisions, it's important for you to remember the following:
    - We make UM decisions by looking at your benefits and clinical guidelines for the most appropriate care and service. We consider your needs, evidence-based practice and availability of care. You also must have active coverage.
    - We don't reward doctors or other people for denying coverage or care.
    - Our employees do not get any incentives to reduce the services you receive.

If you have questions about UM, call Member Services. They can also help if you need language translation or assistance.

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 *Member Handbook.*

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 *Member Handbook*:
    - For more information about when you can join a new MA or drug benefit plan.
    - For information about how you'll get your Michigan Medicaid 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 *Member Handbook* 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

In Michigan, you can create a legal document called a **Durable Power of Attorney for Health Care (DPOA-HC)**. This document allows you to name a patient advocate who can make medical decisions for you if you become incapacitated and can't make your own decisions. The DPOA-HC may include an "Advance Directive" as described below. 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.
- Choose whether or not to fill out an advance directive.

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 Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems at **1-800-882-6006**.

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

Chapter 9 of this *Member Handbook* 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 *Member Handbook* – or you want more information about your rights, you can call:

- Member Services
- The MI Options program at **1-800-803-7174**. For more details about MI Options, refer to **Chapter 2**
- The MI Community, Home, and Health Ombudsman (MI CHHO) at 1-888-746-MHLO (**1-888-746-6456**). For more details about this program, refer to **Chapter 2** of this *Member Handbook*.

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).
Medicaid Customer Help - MSA/MDHHS at 1-800-642-3195. For Michigan calls only, call 1-800-642-3195.

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 *Member Handbook*** 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 *Member Handbook*. 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 *Member Handbook.*
- **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:
  - Medicare Part A and Medicare Part B premiums. For most Aetna Medicare HIDE (HMO D-SNP) members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - For some of you drugs covered by our plan, you must pay your share of the cost when you get the drug. This will be a copay (a fixed amount). **Chapter 6** tells what you must pay for your drugs.
  - **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 *Member Handbook* 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 Michigan Medicaid your new address when you move. Refer to **Chapter 2** of

this *Member Handbook* for phone numbers for Medicare and Michigan Medicaid.
    - **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. Quality Improvement (QI) Program

The Quality Improvement (QI) Program helps us to make sure that our services meet high standards for safety and quality.

We annually make our QI program information available to our members. We look at ways to better members':

- Satisfaction
- Safety
- Services
- Access to doctors

We also always look for ways to make our services better. We do that by:

- Measuring the quality and effectiveness of care and services
- Making sure we use the best ways to check our services
- Having qualified, competent and knowledgeable staff
- Focusing on important problem areas
- Being aware of our members' culture and language needs
- Making sure that we meet state and federal laws
- Meeting all requirements of health care accreditation
- Making sure we have a good network of doctors and hospitals
- Making sure doctors and staff keep member info private

Every year we review our QI Program to be sure it meets guidelines. This helps us make the QI Program better for next year. For more info on our QI programs, go to **AetnaBetterHealth.com/michigan/quality-improvement-program.html**.

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.**

You should get the health care, drugs, long-term supports and services, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your care plan. You should try to work with your providers and Aetna Medicare HIDE (HMO D-SNP) first. If you're **still having a problem with your care or our plan, you can call the MI Community, Home, and Health Ombudsman (MI CHHO) at 1-888-746-6456**. This chapter explains the different options you have for different problems and complaints, but you can always call the MI CHHO to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** for more information on ombudsman programs.

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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 **1-855-676-5772** (**TTY:** 711), 8 AM to 8 PM, 7 days a week, to help deal with a problem or answer questions.

Help from the MI Options
You can call the MI Options at **1-800-803-7174**. You can also review their website at **michigan.gov/MDHHSMIOptions**. MI Options counselors can answer your questions and help you understand what to do about your problem. MI Options isn’t connected with us or with any insurance company or health plan. MI Options has trained counselors in every county, and services are free.

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



If you have questions, please call Aetna Medicare HIDE (HMO D-SNP) at **1-855-676-5772** (TTY: 711), 8 AM to 8 PM, 7 days a week. The call is free. **For more information**, visit **AetnaMedicare.com/MICHDSNP**.

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

Help and information from Michigan Medicaid
You can call the Beneficiary Help Line at **1-800-642-3195** from 8 AM - 7 PM Monday through Friday (except holidays) or email **beneficiarysupport@michigan.gov**. The Beneficiary Support website can be found at **www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/supportht**.

C. Understanding Medicare and Michigan Medicaid complaints and appeals in our plan

You have Medicare and Michigan Medicaid. Information in this chapter applies to all your Medicare and Michigan Medicaid benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Michigan Medicaid processes.

Sometimes Medicare and Michigan Medicaid processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a Michigan Medicaid 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, long term supports and 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.

NOTE: Medicaid specialty behavioral health services are covered by the Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. If the PIHP makes a coverage decision and you don't agree with it, you must appeal to the PIHP. Information about the PIHP in your area is found **Chapter 4** of this *Member Handbook*.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay 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 H** of this *Member Handbook*).

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 and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Michigan Medicaid. 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 a 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:

- Call your Care Coordinator at **1-855-676-5772** (TTY: **711**).
- **Member Services** at the numbers at the bottom of the page.
- Call the **MI Options** for free help. MI Options is an independent organization. It is not connected with this plan. The phone number is **1-800-803-7174**.
- Call the **MI Community, Home, and Health Ombudsman (MI CHHO)** for free help. The MI CHHO can help you with questions about or problems with MI Coordinated Health (MICH) program or our plan. The MI CHHO is an independent program and is not connected with this plan. The phone number is **1-888-746-6456**.
- **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.
- **Michigan Long Term Care Ombudsman Program (MLTCOP)** - MLTCOP strives to improve the quality of care and quality of life experienced by residents who live in nursing homes, homes for the aged, and adult foster care homes. MLTCOP includes both the State Ombudsman and staff and a network of local ombudsmen whom the State Ombudsman program trains, designates, and supervises. To contact a local ombudsman in your area, call **866-485-9393** or send us an email **mltcop.org/contact**.

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.

If you need other help or information, please call the MI CHHO at 1-888-746-MHLO (1-888-746-6456).

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 *Member Handbook* 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 prescription 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: 1-855-676-5772, TTY: 711.
- Faxing: 1-855-259-2087
- Writing:
  Aetna Medicare HIDE (HMO D-SNP)
  Aetna Duals COE Member Correspondence

  PO Box 982980
  El Paso, TX 79998
  Utilization Management

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 **1-855-676-5772** (TTY: **711**).

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-855-676-5772** (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 day**s 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 – Fair Hearing with the state yourself as soon as the time is up. In Michigan Fair Hearings are held by the Michigan Office of Administrative Hearings and Rules (MOAHR).
- **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 – Fair Hearing with the state yourself as soon as the time is up. In Michigan, Fair Hearings *are held by the Michigan Office of Administrative Hearings and Rules (MOAHR).*

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. The IRO will notify you in writing when it gets your appeal.
- If your problem is about coverage of a Michigan Medicaid service or item, the letter tells you how to file a Level 2 Appeal yourself.

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, Michigan Medicaid 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 Michigan Medicaid 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 Michigan Medicaid** 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 Michigan Medicaid, 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 Michigan Medicaid

A Level 2 Appeal for services that Michigan Medicaid usually covers is a Fair Hearing with the state. In Michigan, Fair Hearings are held by the Michigan Office of Administrative Hearings and Rules (MOAHR). 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.

The Fair Hearing office gives you their decision in writing and explain 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. The only amount you should be asked to pay is the copay for Part D drugs on the following tiers: 3, 4, and 5.

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 item.

For more information, refer to **Chapter 7** of this *Member Handbook*. 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 did not 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 Michigan Medicaid 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 Michigan Medicaid 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. For drugs covered only by Medicaid follow the process in **Section E.**

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 *Member Handbook* 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.**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering 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*.**
   - If we agree to make an exception and cover a drug that is not on the Drug List, you pay the copay that applies to drugs on Tier 4.
   - You can't get an exception to the required copay amount for the drug.
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 *Member Handbook* 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.
  - If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you’re required to pay.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our *Drug List* is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.
  - Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs.
  - If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
    - If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
    - If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
  - You can’t ask us to change the cost-sharing tier for any drug in Tier 5: Specialty.
  - If we approve your tiering exception request and there’s more than one lower cost-sharing tier with alternative drugs you can’t take, you usually pay the lowest amount.

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. If you ask us for a tiering exception, we generally **don’t** approve your exception request unless all alternative drugs on the lower cost-sharing tier(s) won’t work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we 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 1-855-676-5772 (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 *Member Handbook*.
- 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 1-855-676-5772 (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 *Member Handbook*.

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/forms-notices/beneficiary-notices-initiative/ffs-ma-im**

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 Michigan, the QIO is Commence Health. Call them at **1-888-524-9900** (**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 MI Options at 1-800-803-7174. **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 the 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/forms-notices/beneficiary-notices-initiative/ffs-ma-im

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 **1-888-524-9900** (**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 your Care Coordinator
  - Call Member Services at the numbers at the bottom of the page.
  - Call the MI Options at **1-800-803-7174**.
  - Call the **MI Community, Home, and Health Ombudsman (MI CHHO)** for free help. The MI CHHO can help you with questions about or problems with the MI Coordinated Health (MICH) program or our plan. The MI CHHO is an independent program and is not connected with this plan. The phone number is **1-888-746-6456**.
  - **Michigan Long Term Care Ombudsman Program (MLTCOP)** - MLTCOP strives to improve the quality of care and quality of life experienced by residents who live in nursing homes, homes for the aged, and adult foster care homes. MLTCOP includes both the State Ombudsman and staff and a network of local ombudsmen whom the State Ombudsman program trains, designates, and supervises. To contact a local ombudsman in your area, call **866-485-9393** or send us an email at **mltcop.org/contact**.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to Chapter 2 of this Member Handbook 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.

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/FFS-Expedited-Determination-Notices**.

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. In Michigan, the Quality Improvement Organization is called Commence Health. You can reach Commence Health at: **1-888-524-9900** (TTY:**1-888-985-8775**).

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.

If you need assistance at any stage of the appeals process, you can contact the MI Community, Home, and Health Ombudsman (MI CHHO). The phone number is 1-888-746-6456.
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 Michigan Medicaid appeals

If your appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision. If you disagree with the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MOAHR at **517-335-2484** for information about requirements you must meet to qualify for a rehearing/reconsideration.

If you need help at any stage of the appeals process, you can contact the MI Community, Home, and Health Ombudsman (MI CHHO). The phone number is 1-888-746-MHLO (1-888-746-6456).

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, 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 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 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 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.

Complaint	Example
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 MI CHHO at 1-888-746-6456.

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 your Care Coordinator or Member Services at 1-855-676-5772 (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 the address listed in **Chapter 2**.
    - 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 a "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.

If you need help at any stage of this process, you can contact the MI Community, Home, and Health Ombudsman (MI CHHO). The phone number is 1-888-746-6456.

K3. External complaints

Medicare
You can tell Medicare about your complaint. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with Aetna Medicare HIDE (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 tell Michigan Medicaid about your complaint
You can also send your complaint to Michigan Medicaid. You can call the Beneficiary Help Line Monday through Friday from 8 AM to 7 PM at 1-800-642-3195 (**TTY:** 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service.

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
233 N. Michigan Ave. Suite 240
Chicago, IL 60601

Phone: 1-800-368-1019
TDD: 1-800-537-7697

Fax: (202) 619-3818

- You may also have rights under the Americans with Disability Act (ADA) and under the Michigan Persons with Disabilities Civil Rights Act (PWDCRA), which protects individuals with disabilities from discrimination in employment, housing, public accommodations, services, and education. You can contact the MI CHHO at **1-888-746-6456** for 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 *Member Handbook*.

In Michigan, the QIO is called Commence Health. The phone number for Commence Health is **1-888-524-9900** (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 Michigan Medicaid programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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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 Michigan Medicaid, 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 Michigan Medicaid 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), MI Options at **1-800-803-7174**.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Member Handbook* 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 Michigan Medicaid 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 1-855-921-PACE (1-855-921-7223). If you need help or more information: • Call the MI Options at 1-800-803-7174. • Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday–Friday 8:00 AM to 8:00 PM. In Michigan, the SHIP is called the MI Options. **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare drug plan **To apply for Medicaid, complete an application online at michigan.gov/mibridges.**	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 MI Options at 1-800-803-7174. • Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday–Friday 8:00 AM to 8:00 PM. In Michigan, the SHIP is called the MI Options. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

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 **To apply for Medicaid, complete an application online at michigan.gov/mibridges.** **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 MI Options at 1-800-803-7174.	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 MI Options at 1-800-803-7174 • Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday–Friday 8:00 AM to 8:00 PM. In Michigan, the SHIP is called the MI Options. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

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. If you need help or more information: • Call the MI Options at 1-800-803-7174 **OR** Enroll in a new Medicare plan You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

C2. Your Michigan Medicaid services

If you leave our plan, you'll get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long-term services and supports and behavioral health care. If you leave our plan you can use any provider that accepts Michigan Medicaid.

Use MI Bridges to update your enrollment information.

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 HIDE (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 Michigan Medicaid eligibility but can be expected to regain it within three months, we'll continue to provide all Medicare benefits covered by Aetna Medicare HIDE (HMO D-SNP). When your Michigan Medicaid coverage ends, we won't pay for your Michigan Medicaid benefits. You will have to pay for any services that you continue to receive that are usually covered by Michigan Medicaid while you're still enrolled with us for your Medicare coverage. We won't continue to cover Medicaid benefits that are included under the Michigan Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period. For more information, please contact your care coordinator or Member Services by calling the phone number listed on the bottom of this page.

We'll assist you to regain your Michigan Medicaid eligibility. If your Michigan Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage:

- Your enrollment with our plan will continue.
- We'll resume paying for your Michigan Medicaid benefits.
- During the Medicaid eligibility review process, you may be responsible for certain copayments or coinsurance amounts for Medicare covered services that Medicaid would normally cover. If you regain Medicaid eligibility within 3 months, coverage may be applied retroactively, and you may be reimbursed for eligible out-of-pocket costs you paid for Medicare-covered services during that period.

If you can't regain Michigan Medicaid within three month(s) we'll disenroll you from Aetna Medicare HIDE (HMO D-SNP). If you regain Michigan Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Call Member Services for more information.

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 *Member Handbook* 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 *Member Handbook.*

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A. Notice about laws

Many laws apply to this *Member Handbook.* These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook.* The main laws that apply are federal laws about the Medicare and Michigan 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, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title IX of the Education Amendments of 1972 (regarding education programs and activities), 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 Michigan Department of Civil Rights at **1-800-482-3604** (**TTY:** **711**).
- 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 Michigan Medicaid 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 Michigan Medicaid is the payer of last resort.

D. Fraud, Waste, and Abuse

Health care fraud affects all of us. It impacts the quality of health care. Aetna Medicare HIDE (HMO D-SNP) is dedicated to fight fraud, abuse and waste through its Fraud Prevention Program. This program is designed to detect and eliminate health care fraud, abuse and waste.

What can you do?
Know what to look for. It can help you protect your identity and benefits. Be suspicious of:

- People trying to sell you health care items or services door-to-door or over the phone
- People who offer money or gifts for health care services
- Bills for services or equipment you didn't get
- Shipments of medical supplies you didn't order
- Someone using your ID card to get medical care, supplies or equipment
- People offering you free gifts or services in exchange for your ID number
- Falsifying timesheets for services not provided or only partially provided
- Incorrectly stating a diagnosis to get higher payments
- Performing unnecessary services to get higher payments

Know Who You're Sharing Information With
Don't be afraid to ask questions if someone asks for your personal information. Never give out your Social Security number, health plan numbers, or banking information to anyone you don't know.

It's important to be able to identify these issues and protect your identity and benefits.

Online theft of personal information
People may try to steal your personal or Medicare or Medicaid information online. They can harm you financially and may disrupt your benefits. It's not always easy to distinguish an important email about your benefits from an online scam. An email may say there's a problem with your account or ask for updated information to continue your coverage.

You can help support our mission to reduce and eliminate fraud in the health care industry by following a few simple guidelines:

- Be careful when providing your health care information, including your Member ID number.
- Be cautious of "free" medical treatments where you are required to provide them with your health care information.
- Understand your benefit plan and what types of treatments, drugs, services, etc., are covered.

Telemarketing Scams
Many legitimate businesses use telemarketing. But criminals can also use live or recorded calls to try to steal your identity. Aetna won't call to ask for your bank account number, Social Security number, Member ID number.

What you can do:

- Hang up on recorded messages that ask you to verify your personal information.
- Don't press any keys or numbers when prompted - even if it's to take your name off their list.
- Never give your personal information to someone you don't know.

If you have questions, please call Aetna Medicare HIDE (HMO D-SNP) at **1-855-676-5772** (TTY: **711**), Seven days a week 8:00 am to 8:00 pm. This call is free. For more information, visit **AetnaMedicare.com/**

MICHDSNP.

Online Pharmacy Scams
Most online pharmacies aren't safe or legal. They might send you medicine that is tampered with, expired, or fake. They could use your personal information to steal your identity.

What you can do:

- Only order from online pharmacies in your health plan's pharmacy network.
- Don't click on links in emails or pop-up advertisements on the internet.
- Don't order from pharmacies outside of the United States.
- Report pharmacies that
  - Offer prescription drugs without a prescription.
  - Won't accept your prescription insurance card as a form of payment.

Lab Test Fraud
Your doctor must order genetic tests for Aetna to cover them. Some labs try to offer a free test in order to get your Aetna information. They may try to steal your identity or submit a fraudulent bill.

What to do before you agree to genetic testing:

- Make sure your doctor ordered the test.
- Make sure the test is medically necessary and the we cover it.

Report concerns to us
You can complete the form at **AetnaMedicare.com/MICHDSNP**. Call Member Services at **1-855-676-5772** (TTY: **711**), Seven days a week 8:00 am to 8:00 pm if you have questions about the form.

You do not need to give us your name or contact information. But if you do, we will keep it confidential. You can also give us just your contact information and not your name.

If you choose not to give your contact information, our review will be only about the information you are reporting. It is important that you give us as much information as you can. It will help us do a complete and correct investigation.

E. Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice took effect on September 1, 2025.

What do we mean when we use the words health information
We use the words "health information" when we mean information that identifies you. Examples include:

- Your name
- Your date of birth
- Health care you received
- Amounts paid for your care

How we use and share your health information
Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care, this could be doctors or drug stores.

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us.

If you are under eighteen and don't want us to give your health information to your parents, call us. We can help in some cases if allowed by state law.

For payment: We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

Health care operations: We may use your health information to help us do our job. For example, we may use your health information for:

- Health promotion
- Case management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

A case manager may work with your doctor. They may tell you about programs or places that can help you with your health. When you call us with questions, we need to look at your health information to give you answers.

Sharing with other businesses
We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair, so they send a van instead of a car to pick you up.

Other reasons we might share your health information
We may also share your health information for these reasons:

- Public safety – To help with things like child abuse. Threats to public health.
- Research – To researchers. After care is taken to protect your information.
- Business partners – To people that provide services to us. They promise to keep your information safe.
- Industry regulation – To state and federal agencies. They check us to make sure we are doing a good job.
- Law enforcement – To federal, state and local enforcement people.
- Legal actions –To courts for a lawsuit or legal matter.

Once health information is shared for any of the reasons above it may potentially be reshared or used for purposes not in this document.

Some state and federal laws may require additional limits on how we use and disclose sensitive health information like mental health or communicable diseases. We will follow the most strict law that applies to your health information.

Reasons that we will need your written okay
Except for what we explained above, we will ask for your okay before using or sharing your health information. For example, we will get your okay:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons when required by law.

You can cancel your okay at any time. To cancel your okay, write to us. We cannot use or share your genetic information when we make the decision to provide you medical insurance.

What are your rights?
You have the right to look at your health information.

- You can ask us for a copy of it
- You can ask for your medical records. Call your doctor's office or the place where you were treated.

You have the right to ask us to change your health information.

- You can ask us to change your health information if you think it is not right.
- If we don't agree with the change, you asked for. Ask us to file a written statement of disagreement.

You have the right to get a list of people or groups that we have shared your health information with. You have the right to ask for a private way to be in touch with you.

- If you think the way we keep in touch with you is not private enough, call us.
- We will do our best to be in touch with you in a way that is more private.

You have the right to ask for special care in how we use or share your health information.

- We may use or share your health information in the ways we describe in this notice.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.

You have the right to know if your health information was shared without your okay.

- We will tell you if we do this in a letter. Call us at the toll-free number on your member ID card to:
  - Ask us to do any of the things above.
  - Ask us for a paper copy of this notice.
  - Ask us any questions about the notice.

You also have the right to send us a complaint. If you think your privacy rights were violated, write to us at **PrivacyAetna@AETNA.com** or:

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079
FAX: 859-280-1272

You also can file a complaint with the Department of Health and Human Services, Office for Civil Rights. Call us to get the address at **1-855-676-5772** (TTY: **711**).

If you are unhappy and tell the Office for Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.

Protecting your information
We protect your health information with specific procedures, such as:

- Administrative. We have rules that tell us how to use your health information no matter what form it is in – written, oral, or electronic.
- Physical. Your health information is locked up and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- Technical. Access to your health information is "role-based." This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

Will we change this notice?
By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. We will mail you the notice if a material change is made. You can get a copy of the most recent notice on our website at **www.aetnabetterhealth.com**.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Member Handbook* 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 *Member Handbook* 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 needing 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 Coordinator: 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."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,400 for Part D covered drugs during the year. You pay nothing.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this *Member Handbook* explains how to contact CMS.

Coinsurance: A percentage (for example, 20%) of the total cost for services or prescription drugs that you need to pay at the time you get them.

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.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays and coinsurance.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this *Member Handbook* 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.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a seven days' supply of the drug, your payment is less than $0.05 per day multiplied by seven days, for a total payment less than $0.35.

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.

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of 5 tiers.

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.

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.”

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 supports and services, and other providers. It also has care coordinators 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.

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP): A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for full-benefit dually eligible individuals. To qualify as a HIDE SNP, a D-SNP must either cover Medicaid behavioral health or long term services and supports (LTSS).

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 more than our cost-sharing amount 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.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $2,400. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

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 *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary."

Long term services and supports (LTSS): 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. LTSS include Community-Based Services and Nursing Facilities (NF).

Low Income Subsidy (LIS): Refer to "Extra Help."

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 *Member Handbook* 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 Handbook* 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.

Member services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Member Handbook* for more information about Member Services.

Michigan Medicaid: This is the name of Michigan's Medicaid program. Michigan Medicaid 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.

MI Coordinated Health (MICH): MICH is a highly integrated dual eligible special needs plan (HIDE SNP) that provides benefits of both Medicare and Medicaid to enrollees. The plan includes all Medicare services and most Medicaid benefits, such as long-term supports and services, with the exception of certain behavioral health and community transition services.

Network: The group of doctors, hospitals, and other healthcare providers that provide covered services to our members.

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.”

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 *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered, or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of this *Member Handbook* 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 *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost-sharing” above.

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 *Member Handbook* 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 *Member Handbook*.

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 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 *Member Handbook* 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 cost-sharing amounts, 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. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

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 *Member Handbook* 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.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

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 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 hearing. If the state 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 HIDE (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	1-855-676-5772 (**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 HIDE Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	Go to AetnaMedicare.com/MICHDSNP 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	Monday–Friday 8:00 AM to 8:00 PM
TTY	711
WRITE	PO Box 30676, Lansing MI 48909
WEBSITE	michigan.gov/MDHHSMIOptions

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