



January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services as a Member of Aetna Medicare Eagle (HMO-POS)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

For questions about this document, call Member Services at [1-833-570-6670](tel:1-833-570-6670) (TTY users call [711](tel:711)). Hours are 8 AM to 8 PM, 7 days a week. This call is free.

This plan, Aetna Medicare Eagle (HMO-POS), is offered by AETNA BETTER HEALTH INC. (GA). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means AETNA BETTER HEALTH INC. (GA). When it says “plan” or “our plan,” it means Aetna Medicare Eagle (HMO-POS).)

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

This document is available for free in other formats such as braille, large print or other alternate formats upon request.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

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

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Aetna Medicare Eagle (HMO-POS)

Section 1.1 You're enrolled in Aetna Medicare Eagle (HMO-POS), which is a Medicare HMO Point-of-Service plan

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

Aetna Medicare Eagle (HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization with a Point-of-Service (POS) option) approved by Medicare and run by a private company. Point-of-Service means you can use providers outside our plan's network for an additional cost. (Go to Chapter 3, Section 2.4 for information about using the Point-of-Service option.) Aetna Medicare Eagle (HMO-POS) doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Aetna Medicare Eagle (HMO-POS) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Aetna Medicare Eagle (HMO-POS) between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Aetna Medicare Eagle (HMO-POS) after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

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

Section 2.2 Plan service area for Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Eagle (HMO-POS) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

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Our service area includes these counties in **Tennessee**: Campbell, Claiborne, Cocke, Grainger, Hamblen, Hancock, Jefferson, Johnson, McMinn, Monroe, Morgan, Roane, Scott.

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

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

Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Aetna Medicare Eagle (HMO-POS) if you're not eligible to stay a member of our plan on this basis. Aetna Medicare Eagle (HMO-POS) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials**Section 3.1 Our plan membership card**

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:

Medicare Plan Type		Website	
			
PLAN NAME LINE PLAN# 000000-00XX0000 ID 10XXXXXXXXXX NAME SAMPLE SAMPLETON BIN 610502 PCN PARTBAET		Customer Service 1-XXX-XXX-XXXX 24 Hour Nurse Line 1-XXX-XXX-XXXX Provider Services 1-XXX-XXX-XXXX TDD/TTY 711	
ISSUER (80840)		Send claims to: Claims PO Box XXXXXX City, State, Zip Code	
PCP \$XX ER \$XX		This card does not guarantee coverage. Payer ID# 60054	
Printed on: xx/xx/xxxx			
HXXXX-PBP			

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Aetna Medicare Eagle (HMO-POS) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

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

Section 3.2 Provider Directory

The *Provider Directory* ([AetnaMedicare.com/findprovider](https://www.aetna.com/findprovider)) lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical group, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Aetna Medicare Eagle (HMO-POS) authorizes use of out-of-network providers.

Our plan is a Medicare Advantage Health Maintenance Organization (HMO) with a Point-of-Service option (POS), which means you may also elect to receive some covered services from out-of-network providers. As a member of this plan, you have the option to use out-of-network providers for non-Medicare covered routine dental services. Go to Chapter 3 for more specific information about the Point-of-Service (POS) option.

Get the most recent list of providers and suppliers on our website at [AetnaMedicare.com/findprovider](https://www.aetna.com/medicare/findprovider).

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

SECTION 4 Summary of Important Costs for 2027

	Your costs in 2027
Monthly plan premium* *Your premium can be higher than this amount. Go to Section 4.1 for details.	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered services. (Go to Chapter 4 Section 1 for details.)	\$4,900
Primary care office visits	\$0 per visit
Specialist office visits	\$35 per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation, and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	\$395 per day, days 1-6; \$0 per day, days 7-90; \$0 copay for additional days for each medically necessary covered inpatient stay.

Your costs can include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan Premium

You don't pay a separate monthly plan premium for Aetna Medicare Eagle (HMO-POS).

Medicare Part B premiums differ for people with different incomes. If you have questions about these

Chapter 1. Get started as a member

premiums, check your copy of *Medicare & You 2027* handbook, in the section called *2027 Medicare Costs*. Download a copy from the Medicare website ([Medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you)) or order a printed copy by phone at 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)). TTY users call [1-877-486-2048](tel:1-877-486-2048).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Part B Premium Reduction

In 2027, we will reduce the Part B premium that you pay to the Social Security Administration by **\$100** per month. If you pay your Part B premium on a monthly basis, you will see this dollar amount credited in your Social Security check. If you pay your Part B premium quarterly, you will see an amount equaling three months of reductions credited on your quarterly Part B premium statement. It may take a few months to see these reductions credited to either your Social Security check or premium statement, but you will be reimbursed for any credits you did not receive during this waiting period.

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

SECTION 5 More information about your monthly plan premium

Section 5.1 Your monthly plan premium won't change during the year

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

SECTION 6 Keep your plan membership record up to date

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

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

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

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

If any of this information changes, let us know by calling Member Services at [1-833-570-6670](tel:1-833-570-6670) (TTY users

call [711](#)).

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

SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

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

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 Aetna Medicare Eagle (HMO-POS) contacts

For help with claims, billing, or member card questions, call or write to Aetna Medicare Eagle (HMO-POS) Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	1-833-570-6670 or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services at 1-833-570-6670 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
Fax	1-866-759-4415
Write	Aetna Medicare PO Box 14088 Lexington, KY 40512
Website	AetnaMedicare.com

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	1-833-570-6670 or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
Fax	1-866-759-4415
Write	Aetna Medicare Precertification Unit PO Box 14079 Lexington, KY 40512
Website	AetnaMedicare.com

Appeals for Medical Care – Contact Information	
Call	1-833-570-6670 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
Fax	1-724-741-4953 Expedited appeals: 1-724-741-4958
Write	Aetna Medicare Part C Appeals PO Box 14067 Lexington, KY 40512
Website	Aetna.com/medicare/contact-us/appeals-grievances.html

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	1-833-570-6670 or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
Fax	1-724-741-4956
Write	Aetna Medicare Grievances PO Box 14834 Lexington, KY 40512
Medicare Website	To submit a complaint about Aetna Medicare Eagle (HMO-POS) directly to Medicare, go to Medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Fax	1-866-474-4040

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Payment Requests – Contact Information	
Write	Aetna Medicare PO Box 981106 El Paso, TX 79998-1106
Website	AetnaMedicare.com

SECTION 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about Aetna Medicare Eagle (HMO-POS). To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

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

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact the Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security – Contact Information	
Call	<u>1-800-772-1213</u> Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	<u>1-800-325-0778</u> This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.

Social Security – Contact Information	
Website	SSA.gov

SECTION 6 Medicaid

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

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

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	https://rrb.gov

SECTION 8 If you have group insurance or other health insurance from an employer

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

You can call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)) with questions about your Medicare coverage under this plan. TTY users call [1-877-486-2048](tel:1-877-486-2048).

CHAPTER 3:

Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

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

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

As a Medicare health plan, Aetna Medicare Eagle (HMO-POS) must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

Aetna Medicare Eagle (HMO-POS) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
- **You get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who’s not part of our plan’s network) won’t be covered. This means you have to pay the provider in full for services you get. *Here are 4 exceptions:*
 - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider. You should get prior authorization from our plan prior to seeking care. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you’re temporarily outside our plan’s service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you’re outside our plan’s service area and get dialysis from a provider that’s outside our plan’s network, your cost sharing can’t be higher than the cost sharing you pay in-network. However, if your usual in-network provider

for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

- Because our plan has a Point-of-Service (POS) option, care you get for certain services from an out-of-network provider (a provider who's not part of our plan's network) may be covered. As a member of this plan, you have the option to use out-of-network providers for non-Medicare covered routine dental services.

SECTION 2 Use providers in our plan's network to get medical care

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

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

As a member of our plan, you **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. If you use a PCP whose name (or office name) is not printed on your member ID card, you may incur a higher cost share or your claims may be denied.

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

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

Please refer to your *Provider Directory* or go to our website at [AetnaMedicare.com/findprovider](https://www.aetna.com/medicare/findprovider) for a complete listing of PCPs in your area.

What is the role of a PCP?

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

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions

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

What is the role of the PCP in making decisions about or obtaining prior authorization (PA), if applicable?

In some cases, your PCP or other provider or you as the enrollee (member) of the plan may need to get approval in advance from our Medical Management Department for certain types of services or tests (this

Chapter 3. Using our plan for your medical services

is called getting “prior authorization”). Obtaining prior authorization is the responsibility of the PCP, treating provider, or you as the member. Services and items requiring prior authorization are listed in Chapter 4.

How to choose a PCP

You can select your PCP by using the *Provider Directory*, by accessing our website at [AetnaMedicare.com/findprovider](https://www.aetna.com/medicare/findprovider), or getting help from Member Services. If you have not selected a PCP, a PCP will be assigned to you. You can change your PCP (as explained later in this section) for any reason, and at any time, by contacting Member Services.

How to change your PCP

You can change your PCP for any reason, at any time. It’s also possible that your PCP might leave our plan’s network of providers and you’d need to choose a new PCP. Contact us immediately if your member ID card does not show the PCP you want to use. We will update your file and send you a new member ID card to reflect the change in PCP.

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.

Section 2.2 Medical care you can get without a PCP referral

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

- Routine women’s health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Behavioral health services as long as you get them from network providers. To access behavioral health services, call the number on your member ID card.
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency), if you’re either temporarily outside our plan’s service area, or if it’s unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you’re temporarily outside our plan’s service area. If possible, call Member Services at **1-833-570-6670** (TTY users call **711**) before you leave the service area so we can help arrange for you to have maintenance dialysis while you’re away.

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

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

- Oncologists care for patients with cancer.

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

What is the role of the PCP in referring members to specialists and other providers?

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. Your PCP may refer you to a specialist, but you can go to any specialists in our network *without* a referral.

Prior authorization process

In some cases, your PCP, other provider, or you as the enrollee (member) of the plan, may need to get approval in advance from our Medical Management Department for certain types of services or tests that you receive in-network (this is called getting “prior authorization”). Obtaining prior authorization is the responsibility of the PCP, treating provider, or you as the member. Services and items requiring prior authorization are listed in the *Medical Benefits Chart* in Chapter 4, Section 2.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving your plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

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

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

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, go to Section 3 in this chapter.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider and you will pay the same as you would pay if you got the care from a network provider. You should get prior

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authorization 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.
- Because our plan has a Point-of-Service (POS) option, care you receive from an out-of-network provider (a provider who is not part of our plan's network) for certain services may be covered. Please see the Medical Benefits Chart in Chapter 4 for the list of services that are covered under your POS option and the costs when you get services from out-of-network providers. As a member of this plan, you have the option to use out-of-network providers for non-Medicare covered routine dental services.

Out-of-network/non-contracted providers are under no obligation to treat our plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

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

You should ask the out-of-network provider to bill us first. If you have already paid for the covered services or if the out-of-network provider sends you a bill that you think we should pay, please contact Member Services or send us the bill. Go to Chapter 5 for information on how to ask us to pay you back or to pay a bill you have received.

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

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services (phone numbers are printed on your member ID card).

Covered services in a medical emergency

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

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

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the Medical Benefits Chart in Chapter 4 for more information. Be sure to get a copy of all your medical records from your emergency care or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.

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

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

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

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care, or
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

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

If you need to locate an urgent care facility, you can find an in-network urgent care center near you by using the *Provider Directory*, going to our website at [AetnaMedicare.com/findprovider](https://www.aetna.com/medicare/findprovider), or getting help from Member Services.

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

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

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the Medical Benefits Chart in Chapter 4 for more information. Be sure to get a copy of all your medical records from your emergency care or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.

Section 3.3 Get care during a disaster

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

Visit [AetnaMedicare.com](https://www.aetna.com) for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

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

If you paid more than our plan cost sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

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

Aetna Medicare Eagle (HMO-POS) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

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

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the

study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

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

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

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

- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at: [Medicare.gov/coverage/clinical-research-studies](https://www.medicare.gov/coverage/clinical-research-studies). You can also call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)). TTY users call [1-877-486-2048](tel:1-877-486-2048).

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

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

As a member of Aetna Medicare Eagle (HMO-POS), we will transfer ownership of certain DME items. In

Original Medicare, there is a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the purchase price is met, you can use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up.

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

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage, Aetna Medicare Eagle (HMO-POS) will cover:

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

If you leave Aetna Medicare Eagle (HMO-POS) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

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

CHAPTER 4:

Medical Benefits Chart

(what's covered and what you pay)

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

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

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

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

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

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

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

Medicare Advantage Plans have limits on the total amount you have to pay out-of-pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027, the MOOP amount is \$4,900.**

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **\$4,900**, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that

amount for any covered services from a network provider.

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

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

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

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked by a note in the Medical Benefits Chart.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at [Medicare.gov](https://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

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

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

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



This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians 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,	\$35 copay for each Medicare-covered acupuncture visit.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Acupuncture for chronic low back pain <i>(continued)</i> 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 get: A CVS Over-the-Counter (OTC) Wallet with a quarterly benefit amount (allowance). See the CVS Over-the-Counter (OTC) Wallet section in Chapter 4 for more details. 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.	There is no coinsurance, copayment, or deductible for the Aetna Medicare Extra Benefits Card.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Aetna® Medicare Extra Benefits Card <i>(continued)</i> • The card can only be used at authorized participating retailers that accept Visa®. Find an authorized participating retailer by visiting CVS.com/Aetna or by using the CVS Flex Benefits™ app. • The card cannot be used to pay for prescription drugs or products such as alcohol, tobacco, cannabis, firearms, lottery, and gift cards. • The card can only be used to pay for eligible products and services incurred while enrolled in the plan. • Aetna is not responsible for unused funds due to personal circumstances in which you cannot use your benefit amount (e.g., hospital stay, travel). • Unused funds will be forfeited. No exceptions will be made to replace unused funds due to a lost or stolen card, personal circumstances, or failure to provide your accurate mailing address to Aetna. • For more information or if you need to request a replacement card, call 1-844-428-8147 (TTY: 711) 7 days a week, 8 AM - 8 PM local time excluding federal holidays. You can also use the CVS Flex Benefits app or visit CVS.com/Aetna.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Prior authorization is required for non-emergency transportation.	\$310 copay for each Medicare-covered one-way trip via ground ambulance. 20% coinsurance for each Medicare-covered one-way trip via air ambulance. Ground or air ambulance cost sharing is <u>not</u> waived if you are admitted to the hospital.
Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to Medicare preventive visit. You may schedule your annual routine physical once each calendar year.	\$0 copay for an annual routine physical exam.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Annual routine physical <i>(continued)</i>	
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 If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year. Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women aged 40 and older • Clinical breast exams once every 24 months Prior authorization may be required and is the responsibility of your provider.	There is no coinsurance, copayment, or deductible for covered screening mammograms. \$0 copay for each diagnostic mammogram.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers 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	\$20 copay for each Medicare-covered cardiac rehabilitation service. \$20 copay for each Medicare-covered intensive cardiac rehabilitation service.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Cardiac rehabilitation services <i>(continued)</i> - 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 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: - Pap tests and pelvic exams once every 24 months for all women - One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct a vertebral subluxation	\$15 copay for each Medicare-covered chiropractic visit.
 Colorectal cancer screening The following screening tests are covered: Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy. Diagnostic colonoscopy: \$0 copay Note: If a polyp is removed or a biopsy is performed during a Medicare-covered
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
 Colorectal cancer screening <i>(continued)</i> months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of 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 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	screening or diagnostic colonoscopy, the polyp removal and associated pathology will be covered at \$0 copay.
CVS Over-the-Counter (OTC) Wallet You get a CVS Over-the-Counter (OTC) Wallet with a \$30 quarterly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card to help pay for:	There is no coinsurance, copayment, or deductible for the CVS Over-the-Counter (OTC) Wallet.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
CVS Over-the-Counter (OTC) Wallet <i>(continued)</i> • Approved over-the-counter (OTC) health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. This benefit includes certain nicotine replacement therapies. • The allowance can only be used to purchase approved OTC products: • In-store at authorized participating CVS® retail locations (excluding locations inside other stores) • Using the CVS Flex Benefits™ app. The app can also be used to locate retail stores and identify covered products. • Online at CVS.com/Aetna • By phone through CVS Flex Benefits at 1-844-428-8147 (TTY: 711). Your quarterly benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each calendar quarter. Calendar quarters begin in January, April, July, and October. Be sure to use the full benefit amount each quarter, because any unused benefit amount will not roll over into the next quarter nor will it roll over into the next plan year. 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.	
Dental services In general, preventive dental services (such as cleanings, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover the following non-Medicare covered benefits: Preventive dental services (non-Medicare covered): For a list of covered preventive services, see the <i>Dental Schedule of Benefits</i>.	\$35 copay for each Medicare-covered dental service. Preventive dental services (non-Medicare covered): For details on cost-sharing for covered preventive services, see the <i>Dental Schedule of Benefits</i>. Comprehensive dental services (non-Medicare covered): For details on cost-sharing for covered comprehensive services, see the <i>Dental Schedule of Benefits</i>. What you must pay when you get these services out-of-network:
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Dental services <i>(continued)</i> Comprehensive dental services (non-Medicare covered): For a list of covered comprehensive services, see the <i>Dental Schedule of Benefits</i>. You get an annual benefit amount (allowance) of \$2,500 for covered comprehensive dental services. Covered preventive dental services do not count toward your annual benefit amount. Covered services will be paid up to the annual benefit amount (allowance). If you exceed the benefit amount for covered comprehensive services, you will be responsible for those costs and will not be reimbursed. This dental benefit has a Point-of-Service (POS) option for non-Medicare covered dental services. That means you can see a provider in or out of the Aetna Dental PPO Network. Out-of-network dentists are not required to accept our plan's payment as payment in full for covered services. Out-of-network claims are reimbursed up to the plan's allowable amount for each covered service. That means our plan will pay its portion for covered services. If your out-of-network provider charges over the allowable amount for a covered service, you may receive a bill and you will be responsible for payment of that bill. For the lowest potential out-of-pocket costs on covered dental services, see a provider in our dental network. Dental services you receive from an out-of-network provider are subject to any benefit maximums, limitations and/or exclusions that may apply. See the <i>Dental Schedule of Benefits</i> for more details. To find a provider in our dental network, visit AetnaMedicare.com/findprovider or call the Member Services number on your member ID card. Note: Our dental network is different than our medical network. Prior authorization may be required and is the responsibility of your provider. *Amounts you pay for preventive dental services do not apply to your maximum out-of-pocket amount. *Amounts you pay for comprehensive dental services do not apply to your maximum out-of-pocket amount.	Preventive dental services (non-Medicare covered): For details on cost-sharing for covered preventive services, see the <i>Dental Schedule of Benefits</i>. Comprehensive dental services (non-Medicare covered): For details on cost-sharing for covered comprehensive services, see the <i>Dental Schedule of Benefits</i>.
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Covered Service	What you pay
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: blood glucose meter • For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting • Diabetes self-management training under certain conditions Important Blood Glucose Meter (BGM) Information: We exclusively cover blood glucose meters (BGMs) manufactured and distributed by Accu-Chek/Roche and TRUE/Trividia that are currently available. Meters 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. • Medical diabetic supplies; blood glucose meters, lancets and control solutions are covered under your medical coverage. • Prior authorizations are required for more than one blood glucose meter per year and may be required for diabetic shoes and inserts. Prior authorization is the responsibility of your provider. Important Continuous Glucose Monitor (CGM) Information:	0% - 20% coinsurance for Medicare-covered diabetic supplies. • 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGM) and medical diabetic supplies. • 20% coinsurance for blood glucose meters (BGM) and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization. 0% coinsurance for Medicare-covered continuous glucose monitors (CGMs). 20% coinsurance for Medicare-covered diabetic shoes and inserts. \$0 copay for Medicare-covered diabetes self-management training.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
 Diabetes self-management training, diabetic services and supplies <i>(continued)</i> • We cover all continuous glucose monitors (CGMs) at DME providers, but we exclusively cover Dexcom and Freestyle Libre at network pharmacies. • Prior authorization may be required for Dexcom and Freestyle Libre continuous glucose monitors (CGMs) at in-network pharmacies if insulin history within the past 6 months cannot be confirmed at the time of dispensing. • Prior authorization may be required for continuous glucose monitors (CGMs) and sensors at a DME provider, if exceeding quantity limits. • If exceeding quantity limits for monitors and sensors that align to Medicare coverage, guidance for prior authorizations is required. Exception requests may also be required. You can find participating network DME pharmacies and suppliers as well as providers for continuous glucose monitors (CGMs) on our website at: AetnaMedicare.com/dme Prior authorization may be required and is the responsibility of your provider.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3.) Covered items include, but aren't limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can 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. 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.	20% coinsurance for each Medicare-covered durable medical equipment (DME) item.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Durable medical equipment (DME) and related supplies <i>(continued)</i> The most recent list of network DME suppliers is available on our website at AetnaMedicare.com/findprovider. To learn more about how DME coverage works, visit AetnaMedicare.com/dme. Prior authorization may be required and is the responsibility of your provider.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. In addition to Medicare-covered benefits, we also offer: • Emergency care (worldwide) • Emergency ambulance services (worldwide) \$250,000 annual maximum benefit for worldwide emergency, emergency ambulance, and urgently needed care. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.	\$130 copay for emergency care. Cost sharing <u>is</u> waived if you are admitted to the hospital within 24 hours. \$130 copay for emergency care worldwide (i.e., outside the United States). Cost sharing <u>is</u> waived if you are admitted to the hospital. \$310 copay for one-way emergency ambulance services worldwide (i.e., outside the United States). Cost sharing is <u>not</u> waived if you are admitted to the hospital. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.
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	\$0 copay for the fitness benefit when you use our authorized vendor, SilverSneakers.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Fitness: Basic SilverSneakers® membership <i>(continued)</i> SilverSneakers. Included with your basic SilverSneakers membership, you will also have access to SilverSneakers online enrichment classes to support your health and wellness, as well as your mental fitness. SilverSneakers health and wellness classes include, but are not limited to: cooking, food and nutrition, and mindfulness. SilverSneakers mental fitness classes include, but are not limited to: new skills, organization, self help, and staying connected. These classes can be accessed online by visiting SilverSneakers.com. To get started, you will need your SilverSneakers ID number. Visit SilverSneakers.com or call SilverSneakers at 1-855-627-3795 (TTY: 711) to obtain this ID number. Then, bring this ID number with you when you visit an authorized participating fitness facility. Information about authorized participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers. Important: You get a basic membership at any authorized participating SilverSneakers location. Facility amenities may vary by participating location including but not limited to hours, days and class types.	
 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 copay for the 24-Hour Nurse Line benefit. \$0 copay for health education.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	\$35 copay for each Medicare-covered hearing exam. \$0 copay for each non-Medicare covered routine hearing exam.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Hearing services <i>(continued)</i> In addition to Medicare-covered benefits, we also offer: • Routine hearing exams: one exam every year • Hearing aid fitting/evaluation: one hearing aid fitting/evaluation every year • Hearing aids: You get an annual benefit amount (allowance) of \$1,250 per ear, every year. When you use our authorized vendor, NationsHearing®, your benefit amount will be applied at the time of purchase. 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. *Amounts you pay for hearing aids do not apply to your maximum out-of-pocket amount.	\$0 copay for each non-Medicare covered hearing aid fitting/evaluation. Hearing aids: \$0 copay per ear, per year (two hearing aids every year).
 HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to:	\$0 copay for each Medicare-covered home health service. 20% coinsurance for each Medicare-covered durable medical equipment (DME) item.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Home health agency care <i>(continued)</i> • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies Prior authorization may be required and is the responsibility of your provider.	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan. Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You will pay the cost sharing that applies to primary care provider services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. (See Physician/practitioner services, including doctor's office visits or Home health agency care for any applicable cost sharing.) Note: Home infusion drugs, pumps, and devices provided during a home infusion therapy visit are covered separately under your Durable medical equipment (DME) and related supplies benefit.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: <i>This benefit is continued on the next page.</i>	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 Eagle (HMO-POS). Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.

Covered Service	What you pay
Hospice care (<i>continued</i>) • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare. For services that are covered by Aetna Medicare Eagle (HMO-POS) but not covered by Medicare Part A or B: Aetna Medicare Eagle (HMO-POS) will continue to cover plan-covered services that aren't covered under Part A or Part B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Covered Service	What you pay
 Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you'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	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. 20% coinsurance for all other vaccines covered under Medicare Part B.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center	\$395 per day, days 1-6; \$0 per day, days 7-90; \$0 copay for additional days for each medically necessary covered inpatient stay. Cost sharing is charged for each medically necessary covered inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities is considered a new admission. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Inpatient hospital care <i>(continued)</i> that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Aetna Medicare Eagle (HMO-POS) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • 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 <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Prior authorization may be required and is the responsibility of your provider. *Amounts you pay for blood do not apply to your maximum out-of-pocket amount.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Days covered: There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Cost sharing is not charged on the day of discharge. Prior authorization may be required and is the responsibility of your provider.	\$470 per day, days 1-5; \$0 per day, days 6-90 for each medically necessary covered inpatient stay. Cost sharing is charged for each medically necessary covered inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Inpatient services in a psychiatric hospital <i>(continued)</i>	
	facilities, and Inpatient Psychiatric facilities is considered a new admission.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your skilled nursing facility benefits, or if the skilled nursing facility or inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	\$0 copay for Medicare-covered primary care provider (PCP) services (including urgently needed services). \$35 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). \$0 - \$200 copay for each Medicare-covered diagnostic procedure and test. • \$0 copay for services provided by your primary care provider in their office. • \$200 copay for services performed by a provider other than your primary care provider.
Prior authorization may be required and is the responsibility of your provider.	\$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing. \$0 copay for each Medicare-covered lab service. \$0 - \$300 copay for each Medicare-covered CT scan. • \$0 copay for services provided by your primary care provider in their office. • \$300 copay for services performed by a provider other than your primary care provider.
	\$0 - \$300 copay for each Medicare-covered diagnostic radiology service other than CT scans. • \$0 copay for services provided by your primary care provider in their office.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay <i>(continued)</i>	• \$300 copay for services performed by a provider other than your primary care provider. \$50 copay for each Medicare-covered x-ray. 20% coinsurance for each Medicare-covered therapeutic radiology service. 0% - 20% coinsurance for Medicare-covered medical supplies. • 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies. 20% coinsurance for each Medicare-covered prosthetic and orthotic device. \$35 copay for each Medicare-covered physical and speech therapy service. \$35 copay for each Medicare-covered occupational therapy service.
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 14 freshly prepared meals for a 7-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. *Amounts you pay for meals do not apply to your maximum out-of-pocket amount.	\$0 copay for the meals benefit when you use our authorized vendor, NationsMarket.

Covered Service	What you pay
 Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed in the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at	\$35 copay for insulin. Insulin cost sharing is subject to a coinsurance cap of \$35 for one-month's supply of insulin and plan level deductibles do not apply. 20% coinsurance for chemotherapy drugs. • This is the maximum cost-share you will pay for Part B prescription drugs. 20% coinsurance for all other drugs covered under Medicare Part B. • This is the maximum cost-share you will pay for Part B prescription drugs. Part B drugs may be subject to Step Therapy requirements.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Medicare Part B drugs (<i>continued</i>) - the time you get immunosuppressive drugs. - Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug - Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision - Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. - 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® - Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics - Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) - Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases - Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: Aetna.com/PartB-Step. We also cover some vaccines under our Part B drug benefit. Prior authorization may be required and is the responsibility of your provider.	

Covered Service	What you pay
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Prior authorization may be required and is the responsibility of your provider.	\$0 copay for each Medicare-covered opioid use disorder treatment service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests Prior authorization may be required and is the responsibility of your provider.	\$50 copay for each Medicare-covered x-ray. 20% coinsurance for each Medicare-covered therapeutic radiology service. 0% - 20% coinsurance for Medicare-covered medical supplies. • 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies. \$0 copay for each Medicare-covered lab service. \$0 copay for Medicare-covered and non-Medicare covered blood services. \$0 - \$300 copay for each Medicare-covered CT scan.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies <i>(continued)</i> *Amounts you pay for blood do not apply to your maximum out-of-pocket amount.	• \$0 copay for services provided by your primary care provider in their office. • \$300 copay for services performed by a provider other than your primary care provider. \$0 - \$300 copay for each Medicare-covered diagnostic radiology service other than CT scans. • \$0 copay for services provided by your primary care provider in their office. • \$300 copay for services performed by a provider other than your primary care provider. \$0 - \$200 copay for each Medicare-covered diagnostic procedure and test. • \$0 copay for services provided by your primary care provider in their office. • \$200 copay for services performed by a provider other than your primary care provider. \$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing. An additional cost share may apply if you receive services from multiple providers.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient	\$395 copay for outpatient hospital observation services per stay.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Outpatient hospital observation <i>(continued)</i> tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Prior authorization may be required and is the responsibility of your provider.	
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Outpatient services not specifically listed with a separate copay will have the outpatient surgery cost share applied. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Prior authorization may be required and is the responsibility of your provider. <i>This benefit is continued on the next page.</i>	\$395 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. \$395 copay for outpatient hospital observation services per stay. \$0 - \$200 copay for each Medicare-covered diagnostic procedure and test. • \$0 copay for services provided by your primary care provider in their office. • \$200 copay for services performed by a provider other than your primary care provider. \$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing. \$0 copay for each Medicare-covered lab service. \$0 - \$300 copay for each Medicare-covered CT scan.

Covered Service	What you pay
Outpatient hospital services <i>(continued)</i>	• \$0 copay for services provided by your primary care provider in their office. • \$300 copay for services performed by a provider other than your primary care provider. \$0 - \$300 copay for each Medicare-covered diagnostic radiology service other than CT scans. • \$0 copay for services provided by your primary care provider in their office. • \$300 copay for services performed by a provider other than your primary care provider. \$50 copay for each Medicare-covered x-ray. 20% coinsurance for each Medicare-covered therapeutic radiology service. \$0 copay for each Medicare-covered individual session for outpatient psychiatrist service. \$0 copay for each Medicare-covered group session for outpatient psychiatrist service. \$0 copay for each Medicare-covered individual session for outpatient mental health service. \$0 copay for each Medicare-covered group session for outpatient mental health service. \$140 copay for each Medicare-covered partial hospitalization day. \$140 copay for each Medicare-covered intensive outpatient visit. 0% - 20% coinsurance for Medicare-covered medical supplies.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Outpatient hospital services <i>(continued)</i>	• 0% coinsurance for continuous glucose monitor supplies. • 20% coinsurance for all other Medicare-covered medical supplies. \$35 copay for insulin. Insulin cost sharing is subject to a coinsurance cap of \$35 for one-month's supply of insulin and plan level deductibles do not apply. 20% coinsurance for chemotherapy drugs. • This is the maximum cost-share you will pay for Part B prescription drugs. 20% coinsurance for all other drugs covered under Medicare Part B. • This is the maximum cost-share you will pay for Part B prescription drugs. \$35 copay for all other outpatient hospital services.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Prior authorization may be required and is the responsibility of your provider.	\$0 copay for each Medicare-covered individual session for outpatient psychiatrist service. \$0 copay for each Medicare-covered group session for outpatient psychiatrist service. \$0 copay for each Medicare-covered individual session for outpatient mental health service. \$0 copay for each Medicare-covered group session for outpatient mental health service.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	\$35 copay for each Medicare-covered occupational therapy service. \$35 copay for each Medicare-covered physical and speech therapy service.

Covered Service	What you pay
Outpatient substance use disorder services Our coverage is the same as Original Medicare's which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use-related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment. • Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change. Prior authorization may be required and is the responsibility of your provider.	\$40 copay for each Medicare-covered individual session for outpatient substance use disorder service. \$40 copay for each Medicare-covered group session for outpatient substance use disorder service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Prior authorization may be required and is the responsibility of your provider.	\$395 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. \$345 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center.
Partial hospitalization services and intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense <i>This benefit is continued on the next page.</i>	\$140 copay for each Medicare-covered partial hospitalization day. \$140 copay for each Medicare-covered intensive outpatient visit.

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services <i>(continued)</i>	
than partial hospitalization.	
Prior authorization may be required and is the responsibility of your provider.	
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, as long as your provider can offer these services via telehealth, including: ◦ Primary care provider services ◦ Physician specialist services ◦ Diabetes self-management training services ◦ Kidney disease education services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Occupational therapy services ◦ Opioid treatment services ◦ Outpatient substance use disorder services (individual sessions) ◦ Outpatient substance use disorder services (group sessions) ◦ Physical and speech therapy services ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services • This coverage is in addition to the telehealth services described below. For more details on your additional telehealth coverage, please review your Aetna Medicare Telehealth Coverage at AetnaMedicare.com/Telehealth ◦ 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.	\$0 copay for Medicare-covered primary care provider (PCP) services (including urgently needed services). Note: If you use a PCP (or PCP office) whose name is not printed on your Member ID card, you may incur a higher cost share or your claims may be denied. If you would like to change your PCP, contact Member Services. \$35 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). \$35 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including: • \$0 copay for each primary care provider service • \$35 copay for each physician specialist service • \$0 copay for each diabetes self-management training service • 20% coinsurance for each kidney disease education service • \$0 copay for each individual session for mental health service • \$0 copay for each group session for mental health service • \$35 copay for each occupational therapy service • \$0 copay for each opioid treatment program service • \$40 copay for each individual session for outpatient substance use disorder service • \$40 copay for each group session for outpatient substance use disorder service
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits <i>(continued)</i> - You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, you may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc, MinuteClinic® Video Visit, or other provider that offers telehealth services covered under your plan. You can access Teladoc at Teladoc.com/ Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711). You can find out if MinuteClinic® Video Visits are available in your area at CVS.com/MinuteClinic/virtual-care/videovisit. - Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare - Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home - Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location - Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location - Telehealth services for diagnosis, evaluation, and treatment of mental health disorders - Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers - Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: - You're not a new patient and - The check-in isn't related to an office visit in the past 7 days and - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment - Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: - You're not a new patient and - The evaluation isn't related to an office visit in the past 7 days and - The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment - Consultation your doctor has with other doctors by phone, internet, or electronic health record	\$35 copay for each physical therapy and speech therapy service \$0 copay for each individual session for psychiatric service \$0 copay for each group session for psychiatric service \$50 copay for each urgently needed service
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits <i>(continued)</i>	
Second opinion by another network provider prior to surgery Prior authorization may be required and is the responsibility of your provider.	
Podiatry services Covered services include: - Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) - Routine foot care for members with certain medical conditions affecting the lower limbs	\$35 copay for each Medicare-covered podiatry visit.
 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 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months - Up to 8 HIV screenings every 12 months - A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
 Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: - Digital rectal exam - Prostate Specific Antigen (PSA) test	\$0 copay for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also	20% coinsurance for each Medicare-covered prosthetic and orthotic device. 0% - 20% coinsurance for Medicare-covered medical supplies. 0% coinsurance for continuous glucose monitor supplies.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies <i>(continued)</i> includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail. Prior authorization may be required and is the responsibility of your provider.	• 20% coinsurance for all other Medicare-covered medical supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	\$15 copay for each Medicare-covered pulmonary rehabilitation service.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
 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 cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
 Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. Eligible members are people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of <i>This benefit is continued on the next page.</i>	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
 Screening for lung cancer with low dose computed tomography (LDCT) <i>(continued)</i> tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	20% coinsurance for each Medicare-covered kidney disease education session. 20% coinsurance for Medicare-covered outpatient dialysis, self-dialysis training, certain home support services, and home dialysis equipment and supplies. \$395 per day, days 1-6; \$0 per day, days 7-90; \$0 copay for additional days for each medically necessary covered inpatient stay. Cost sharing is charged for each medically necessary covered inpatient stay.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Services to treat kidney disease <i>(continued)</i> • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table. Prior authorization may be required and is the responsibility of your provider.	Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities is considered a new admission. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) Days covered: up to 100 days per benefit period. A prior hospital stay is not required. We will only cover your stay if you meet certain Medicare guidelines and your stay is medically necessary. Cost sharing is not charged on the day of discharge. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood – including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services	\$10 per day, days 1-20; \$221 per day, days 21-100 for each Medicare-covered SNF stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Skilled nursing facility (SNF) care <i>(continued)</i> Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital Prior authorization may be required and is the responsibility of your provider. *Amounts you pay for blood do not apply to your maximum out-of-pocket amount.	
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) In addition to Medicare-covered benefits, we also offer: • Additional (non-Medicare covered) individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. \$0 copay for each additional non-Medicare covered smoking and tobacco use cessation visit.
Special supplemental benefits You may be eligible for additional benefits. See the Special Supplemental Benefits Chart following the Medical Benefits Chart for information on benefits and eligibility requirements.	See the Special Supplemental Benefits Chart for information.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	\$25 copay for each Medicare-covered supervised exercise therapy (SET) service.
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
Supervised exercise therapy (SET) <i>(continued)</i> The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. In addition to Medicare-covered benefits, we also offer: • Urgent care (worldwide) \$250,000 annual maximum benefit for worldwide emergency care, emergency ambulance, and urgently needed care. You may have to pay the provider at the time of service and submit for reimbursement. You will be reimbursed up to the annual maximum benefit amount less any applicable copay or cost share.	\$50 copay for each Medicare-covered urgent care facility visit. Cost sharing is <u>not</u> waived if you are admitted to the hospital. (See Physician/practitioner services, including doctor's office visits for information about urgently needed services provided in a physician's office.) \$130 copay for each urgent care visit worldwide (i.e., outside the United States). Cost sharing is <u>not</u> waived if you are admitted to the hospital.
 Vision care Covered services include:	\$35 copay for each Medicare-covered eye exam. If you receive additional services during the eye exam, such as but not limited to
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
 Vision care <i>(continued)</i> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk for glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. The services described above must be provided by an Aetna network provider to be covered. To find an Aetna network provider, visit AetnaMedicare.com/findprovider or call the number on your member ID card. Eye refractions for eyeglasses/contacts, even in support of any of the above eye illness or diagnostic services, are not covered under your medical services. See below for when refraction is covered. 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 • This exam must be with an EyeMed network provider to be covered. To find an EyeMed provider, visit AetnaMedicareVision.com or call the number on your member ID card. Information about refraction (vision test for glasses): We cover refraction once per plan year during either: • A non-Medicare covered routine eye exam with an EyeMed network provider. OR <i>This benefit is continued on the next page.</i>	lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received. \$0 copay for one Medicare-covered glaucoma screening. \$0 copay for the Medicare-covered initial diabetic eye exam each year. \$0 copay for each follow-up diabetic eye exam. \$0 copay for Medicare-covered eyewear after cataract surgery. \$0 copay for one non-Medicare covered routine eye exam including refraction with an EyeMed provider. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received.

Covered Service	What you pay
 Vision care <i>(continued)</i> - A Medicare-covered eye exam with an Aetna network provider that is also in the EyeMed network. Limitations for refractions: - One refraction covered per plan year. - If you receive a refraction with a routine eye exam, it will not be covered again during a Medicare covered eye exam in the same year. - If a refraction is done during a Medicare-covered eye exam, a separate routine eye exam will not be covered in the same plan year. *Amounts you pay for non-Medicare covered routine eye exams do not apply to your maximum out-of-pocket amount. *Amounts you pay for follow-up diabetic eye exams do not apply to your maximum out-of-pocket amount.	
Vision care — eyewear (non-Medicare covered) With this plan you get an annual benefit amount (allowance) of \$200 every year for prescription eyewear including: - Contact lenses - Eyeglasses including lenses and frames - Eyeglass lenses - Eyeglass frames - Upgrades (including UV protection and scratch coating) We have teamed up with EyeMed to provide this benefit. You must see a provider in the EyeMed network for your eyewear benefit to be covered. Your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll just need to pay the difference. To find a participating EyeMed provider, you can search online at AetnaMedicareVision.com or call the number on your member ID card. *Amounts you pay for additional eyewear services do not apply to your maximum out-of-pocket amount.	Covered prescription eyewear: - Contact lenses: \$0 copay - Eyeglasses (lenses and frames): \$0 copay - Eyeglass lenses: \$0 copay - Eyeglass frames: \$0 copay - Upgrades (including UV protection and scratch coating): \$0 copay
 Welcome to Medicare preventive visit Our plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed.	There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. \$0 copay for a Medicare-covered EKG following the Welcome to Medicare
<i>This benefit is continued on the next page.</i>	

Covered Service	What you pay
 Welcome to Medicare preventive visit <i>(continued)</i>	
Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	preventive visit.
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. You can purchase wigs through a durable medical equipment (DME) supplier or a supplier of your choice. You are responsible for any costs over the benefit amount. To find a DME supplier, you can call the phone number on your member ID card or visit our online directory at AetnaMedicare.com/findprovider. If you choose to use a supplier that is not in the DME network, you will need to pay out-of-pocket and submit a claim for reimbursement along with the receipt. You will only be reimbursed up to the benefit amount. You can find the reimbursement form at AetnaMedicare.com/forms.	\$0 copay for a wig.

Special Supplemental Benefits Chart	
Members enrolled in this plan may qualify for additional benefits. The chart below describes the eligibility requirements and benefits that may be available.	
Aetna Cancer Care Support Program	
Eligibility requirements: If you have been diagnosed with cancer by a medical professional and are receiving active cancer treatment, you may be eligible for the Aetna Cancer Care Support Program. If you are eligible for this program, you will be contacted by phone and/or mail to notify you of your eligibility. You will be provided with additional information to help you better understand the benefits offered by this program. This is a voluntary program. If you are notified that you are eligible for this program, you can decide if you want to participate or not. If you have questions about this program or your eligibility, call the Member Services number on your member ID card. Important: Eligibility for this program is determined through medical claims review. You cannot self-attest to a cancer diagnosis.	
Benefits	What you must pay when you get these services
If you qualify, you can get certain in-person and/or telehealth oncology/specialist office visits with an Aetna-designated provider participating in this program.	\$0 copay for each office visit with an Aetna-designated oncologist/specialist.

**2027 Deluxe EPO POS Mandatory
Dental Schedule of Benefits**

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

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

Comprehensive Services				
Maximum Benefit: \$2,500				
What you must pay when you get these services				
CDT Code	Description	Frequency	in-network	out-of-network
D2140	amalgam - one surface, primary or permanent	Two procedures from this code group per tooth per calendar year	20%	50%
D2150	amalgam - two surfaces, primary or permanent		20%	50%
D2160	amalgam - three surfaces, primary or permanent		20%	50%
D2161	amalgam - four or more surfaces, primary or permanent		20%	50%
D2330	resin-based composite - one surface, anterior		20%	50%
D2331	resin-based composite - two surfaces, anterior		20%	50%
D2332	resin-based composite - three surfaces, anterior		20%	50%
D2335	resin-based composite - four or more surfaces (anterior)		20%	50%
D2390	resin-based composite crown – direct		20%	50%
D2391	resin-based composite - one surface, posterior		20%	50%
D2392	resin-based composite - two surfaces, posterior		20%	50%
D2393	resin-based composite - three surfaces, posterior		20%	50%
D2394	resin-based composite - four or more surfaces, posterior		20%	50%
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	One procedure from this code group per tooth per calendar year	20%	50%
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core		20%	50%
D2920	re-cement or re-bond crown		20%	50%
D3310	endodontic therapy, anterior tooth (excluding final restoration)	One procedure from this code group per tooth per lifetime	20%	50%
D3320	endodontic therapy, premolar tooth (excluding final restoration)		20%	50%
D3330	endodontic therapy, molar tooth (excluding final restoration)		20%	50%
D3346	retreatment of previous root canal therapy - anterior	One procedure from this group per tooth per lifetime	20%	50%
D3347	retreatment of previous root canal therapy - premolar		20%	50%

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

CDT Code	Description	Frequency	in-network	out-of-network
D2791	crown - full cast predominantly base metal		50%	70%
D2792	crown - full cast noble metal		50%	70%
D2980	crown repair necessitated by restorative material failure	one per tooth per calendar year	50%	70%
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	one per lifetime	50%	70%
D5110	complete denture - maxillary	One procedure from this code group including D5110, D5120, D5130, D5140, D5521, D5522, D5877, and D5878 per arch every 5 years	50%	70%
D5120	complete denture - mandibular		50%	70%
D5130	immediate denture - maxillary		50%	70%
D5140	immediate denture - mandibular		50%	70%
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	One procedure from this code group, per arch every 5 years	50%	70%
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)		50%	70%
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	70%
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	70%
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)		50%	70%
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)		50%	70%
D5282	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary		50%	70%
D5283	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D5284	removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant		50%	70%
D5286	removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant		50%	70%
D5410	adjust complete denture - maxillary	as needed	50%	70%
D5411	adjust complete denture - mandibular		50%	70%
D5421	adjust partial denture - maxillary		50%	70%
D5422	adjust partial denture - mandibular		50%	70%
D5511	repair complete denture base, mandibular		50%	70%
D5512	repair complete denture base, maxillary		50%	70%
D5520	replace missing or broken teeth – complete denture – per tooth	One procedure from this code group including D5110, D5120, D5130, D5140, D5521, D5522, D5877, and D5878 per arch every 5 years	50%	70%
D5521	replace all teeth on complete denture – maxillary		50%	70%
D5522	replace all teeth on complete denture – mandibular		50%	70%
D5611	repair resin partial denture base, mandibular	as needed	50%	70%
D5612	repair resin partial denture base, maxillary		50%	70%
D5621	repair cast partial framework, mandibular		50%	70%
D5622	repair cast partial framework, maxillary		50%	70%
D5630	repair or replace broken retentive clasping materials – per tooth		50%	70%
D5640	replace missing or broken teeth – partial denture – per tooth		50%	70%
D5650	add tooth to existing partial denture – per tooth		50%	70%
D5660	add clasp to existing partial denture - per tooth		50%	70%
D5670	replace all teeth and acrylic on cast metal framework (maxillary)		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D5671	replace all teeth and acrylic on cast metal framework (mandibular)		50%	70%
D5710	rebase complete maxillary denture		50%	70%
D5711	rebase complete mandibular denture		50%	70%
D5720	rebase maxillary partial denture		50%	70%
D5721	rebase mandibular partial denture		50%	70%
D5730	reline complete maxillary denture (direct)		50%	70%
D5731	reline complete mandibular denture (direct)		50%	70%
D5740	reline maxillary partial denture (direct)		50%	70%
D5741	reline mandibular partial denture (direct)		50%	70%
D5750	reline complete maxillary denture (indirect)		50%	70%
D5751	reline complete mandibular denture (indirect)		50%	70%
D5760	reline maxillary partial denture (indirect)		50%	70%
D5761	reline mandibular partial denture (indirect)		50%	70%
D5876	add metal substructure to acrylic complete denture - per arch		50%	70%
D5877	duplication of complete denture - maxillary	One procedure from this code group including D5110, D5120, D5130, D5140, D5521, and D5522 per arch every 5 years	50%	70%
D5878	duplication of complete denture - mandibular		50%	70%
D6980	fixed partial denture repair necessitated by restorative material failure	N/A	50%	70%
D6210	pontic - cast high noble metal	One procedure from this code group per tooth every 5 years	50%	70%
D6211	pontic - cast predominantly base metal		50%	70%
D6212	pontic - cast noble metal		50%	70%
D6240	pontic - porcelain fused to high noble metal		50%	70%
D6241	pontic - porcelain fused to predominantly base metal		50%	70%
D6242	pontic - porcelain fused to noble metal		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D6243	pontic - porcelain fused to titanium and titanium alloys		50%	70%
D6245	pontic - porcelain/ceramic		50%	70%
D6250	pontic - resin with high noble metal		50%	70%
D6251	pontic - resin with predominantly base metal		50%	70%
D6252	pontic - resin with noble metal		50%	70%
D6545	retainer - cast metal for resin bonded fixed prosthesis	One procedure from this code group per tooth every 5 years	50%	70%
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis		50%	70%
D6720	retainer crown - resin with high noble metal		50%	70%
D6721	retainer crown - resin with predominantly base metal		50%	70%
D6722	retainer crown - resin with noble metal		50%	70%
D6740	retainer crown - porcelain/ceramic		50%	70%
D6750	retainer crown - porcelain fused to high noble metal		50%	70%
D6751	retainer crown - porcelain fused to predominantly base metal		50%	70%
D6752	retainer crown - porcelain fused to noble metal		50%	70%
D6753	retainer crown - porcelain fused to titanium and titanium alloys		50%	70%
D6780	retainer crown - 3/4 cast high noble metal		50%	70%
D6781	retainer crown - 3/4 cast predominantly base metal		50%	70%
D6782	retainer crown - 3/4 cast noble metal		50%	70%
D6783	retainer crown - 3/4 porcelain/ceramic		50%	70%
D6784	retainer crown ¾ - titanium and titanium alloys		50%	70%
D6790	retainer crown - full cast high noble metal		50%	70%
D6791	retainer crown - full cast predominantly base metal		50%	70%
D6792	retainer crown - full cast noble metal		50%	70%
D7230	removal of impacted tooth - partially bony	one extraction per tooth per lifetime	50%	70%
D7240	removal of impacted tooth - completely bony		50%	70%

CDT Code	Description	Frequency	in-network	out-of-network
D7241	removal of impacted tooth - completely bony, with unusual surgical complications		50%	70%
D9128	photobiomodulation therapy - first 15 minute increment, or any portion thereof	N/A	50%	70%
D9129	photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof	N/A	50%	70%
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	N/A	50%	70%
D9222	administration of deep sedation/ general anesthesia – first 15 minute increment, or any portion thereof		50%	70%
D9223	administration of deep sedation/ general anesthesia – each subsequent 15 minute increment, or any portion thereof		50%	70%
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof		50%	70%
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof		50%	70%
D9239	administration of moderate sedation – intravenous - first 15 minute increment, or any portion thereof		50%	70%
D9243	administration of moderate sedation – intravenous - each subsequent 15 minute increment, or any portion thereof		50%	70%
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof		50%	70%
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof		50%	70%
D9613	infiltration of sustained release therapeutic drug, per quadrant		50%	70%

Out-of-pocket costs

You will be responsible for payment of services and charges billed by a provider that exceed coverage limitations. You may also be required to pay your cost share at the time of service. Billing arrangements are between you and the provider. In addition, if you obtain services from a dental provider that is not part of our network, you may be required to pay up to the cost of the service at the time services are provided

and then submit for reimbursement. The reimbursement request will be reviewed and a decision will be made based upon the information provided. Reimbursement is not guaranteed. You can submit a Medical Member Reimbursement Form to Aetna Medicare, PO Box 981106, El Paso, TX 79998-1106. You can get this form by calling Member Services or you can fill out and submit the form online at [AetnaMedicare.com/forms](https://www.aetna.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, relines, or rebase are not covered.
23. Denture relines 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, relines, or rebase are not

covered.

25. For covered dental procedures listed in your schedule of benefits, the treatment date for billing purposes is defined by completion of specific procedures.
For removable dentures (complete and partial), this is the delivery date. For inlays, onlays, crowns, veneers and bridges, it's the date of final cementation. For root canals, it's the date the final fill is placed.
26. Procedures that are considered experimental, investigational or unproven are not covered. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics.
27. If this policy is terminated or the covered dental services for this plan change, this plan will not cover ongoing care or treatment. This includes all multi-appointment procedures.
28. Services and supplies provided in connection with treatment or care that is not covered under the plan are not covered.

Medical Necessity

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

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

Medical necessity is determined using criteria that are:

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

Alternate Benefits

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

An advance claim review

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

When to get an advance claim review

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

1. Ask your dentist to write down a full description of the treatment you need. They must either use an

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

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

Section 2.1 Get care using your plan’s optional visitor/traveler benefit

If you are outside of your plan’s service area for more than 6 months, we are required to disenroll you from your Aetna Medicare plan. However, your plan includes a visitor/traveler program when you travel within the United States (except California and Puerto Rico). This program lets you stay enrolled in your plan while you are away from your service area for more than 6 months and up to 12 months. While you are using the visitor/traveler program, you can get covered services at in-network costs as long as you see a network provider. In most cases, non-urgent/non-emergency care you receive from an out-of-network provider (a provider who is not an Aetna Medicare provider) will not be covered. Contact us for help finding an in-network provider in the area you’re traveling to.

If you don’t return to your plan’s service area within 12 months, you will be disenrolled from the plan. Please let us know before you travel if you expect to be outside your plan’s service area for more than 6 months.

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself, except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered and our plan won’t pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	• Available for people with chronic low back pain under certain circumstances.

Services not covered by Medicare	Covered only under specific conditions
Cosmetic surgery or procedures	• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition.
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. • (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition.
Full-time nursing care in your home	Not covered under any condition.
Home-delivered meals	• Our plan provides some coverage for home-delivered meals as described in the Medical Benefits Chart.
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition.
Private room in a hospital	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition.
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position) is covered. Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. All other services, including maintenance therapy, are not covered under Medicare.
Routine dental care, such as cleanings, fillings or dentures	Our plan provides some coverage for dental services as described in the Medical Benefits Chart.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	- One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. - Routine eye exams: Our plan provides some coverage for routine eye exams as described in the Medical Benefits Chart. - Eyewear: Our plan provides some additional coverage for eyewear as described in the Medical Benefits Chart.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).

Services not covered by Medicare	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids	• Medicare covers diagnostic hearing exams and balance exams if ordered by a physician. • Routine hearing exams: Our plan provides some coverage for routine hearing exams as described in the Medical Benefits Chart. • Hearing aid fitting and evaluations: Our plan provides some coverage for hearing aid fitting and evaluations as described in the Medical Benefits Chart. • Hearing aids: Our plan provides some coverage for hearing aids as described in the Medical Benefits Chart.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition.
Therapeutic Massage	Not covered under any condition.

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

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

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

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

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

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

Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

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

2. When a network provider sends you a bill you think you shouldn't pay

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

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

3. If you're retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your medical and Part B vaccine claims to us within 12 months** of the date you got the service, item, or Part B drug.

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

- You don't have to use the form, but it'll help us process the information faster. The form requires you to provide information such as: name, address, Aetna Medicare ID number, provider name, provider NPI (national provider identifier), provider TIN (taxpayer identification number), provider address, date of service, reimbursement type, description of service(s), and charge(s).
- Download a copy of the form from our website ([AetnaMedicare.com](https://www.aetnamedicare.com)) or call Member Services at **1-833-570-6670** (TTY users call **711**) and ask for the form.

For medical claims (including vaccines for preventing COVID-19, Flu/influenza, Pneumonia): Mail your request for payment together with any bills or paid receipts to us at this address:

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

Chapter 5. Asking us to pay our share of a bill for covered medical services

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

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

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

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

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

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

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

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

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder las preguntas de los miembros que no hablan inglés. También podemos brindarle información en otros idiomas además de

Chapter 6. Your rights and responsibilities

inglés, incluido español y braille, en letra grande u otros formatos alternativos, sin costo alguno si lo necesita. Tenemos la obligación de brindarle información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener información nuestra de una manera que sea conveniente para usted, llame a Servicios para Miembros al [1-833-570-6670](tel:1-833-570-6670) (los usuarios de TTY deben llamar al [711](tel:711)).

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

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

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

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

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. We don't require you to get referrals to go to network providers.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we're required to get written permission from you or someone you have given legal power to make decisions for you first*.

- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

You have the right to know how your health information has been shared with others for any purposes that aren't routine. You have the right to make recommendations regarding our organizations member rights and responsibilities policy.

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

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

As a member of Aetna Medicare Eagle (HMO-POS), you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.
- **Information from interpreters.** Our plan interpreter services are available in all languages including American Sign Language. Interpreter services are available for on-site interpretation during a medical appointment. If you require these services, please contact Member Services at least two weeks in advance of your scheduled appointment.

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

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions

with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

How to set up an advance directive to give instructions:

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

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

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

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

If your instructions aren't followed

If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your State Health Insurance Assistance Program (SHIP). Contact information is in **Appendix A** at the back of this document.

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

If you have any problems, concerns, or complaints and need to ask for coverage or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint — **we’re required to treat you fairly.**

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

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

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

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

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

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

SECTION 2 Your responsibilities as a member of our plan

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what’s covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you’re required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you’re enrolled in our plan.** Show our plan membership card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you’re taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.

Chapter 6. Your rights and responsibilities

- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
 - For most of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

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

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

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

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

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

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

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

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

SECTION 2 Where to get more information and personalized help

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare help:

- Call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.
- Visit [Medicare.gov](https://www.medicare.gov).

SECTION 3 Which process to use for your problem

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we will give you our decision.

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

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

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

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

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

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

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal**Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care**

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

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision**Legal Terms:**

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

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

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

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

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- You may *only* ask for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision asked for.

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

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

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

For standard coverage decisions we use the standard deadlines.

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

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**, if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 for

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information on complaints.) We'll call you as soon as we make the decision.

- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal**Legal Terms:**

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

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

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

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

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

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

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

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give

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you our answer sooner if your health requires us to.

- If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
- If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we *shouldn't* take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

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

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**

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- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have 72 hours from the date we receive the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal.

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

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

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at **1-833-570-6670** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

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

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.

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

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

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

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

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

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

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Appendix A** at the back of this document.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without* paying for it while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at **1-833-570-6670** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**) TTY users call **1-877-486-2048**. Or you can get a sample notice online at [CMS.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im](https://www.cms.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im).

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

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ends.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

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

Section 7.1 We'll tell you in advance when your coverage will be ending**Legal Term:**

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to request a *fast-track appeal* to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

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

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Appendix A** at the back of this document.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in **Appendix A** at the back of this document.

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**What happens if the reviewers say yes?**

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

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4, and 5

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

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

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Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting the deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2**How to make a complaint**

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)**Legal Term:**

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly — either by phone or in writing.

- **Calling Member Services at 1-833-570-6670 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- To use our grievance (complaint) process, you should call or send us your written complaint using one of the contact methods listed in Chapter 2: *Phone numbers and resources*.
 - Please be sure you provide all pertinent information, including any supporting documents you believe are appropriate. Your complaint must be received by us within 60 calendar days of the event or incident that resulted in you filing your complaint.
 - Your issue will be investigated by a member of our complaint team. If you submit your complaint verbally, we will inform you of the result of our review and our decision verbally or in writing. If you submit a verbal complaint and request your response to be in writing, we will respond in writing. If you send us a written complaint, we will send you a written response, stating the result of our review. Our notice will include a description of our understanding of your complaint and our decision in clear terms.
 - We must address your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if we justify a need for additional information and the delay is in your best interest.
 - You also have the right to ask for a fast "expedited" grievance. A fast "expedited" grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a fast "expedited" grievance if you disagree with:
 - Our plan to take a 14-calendar-day extension on an organization/coverage determination or reconsideration/redetermination (appeal); or
 - Our denial of your request to expedite an organization determination or reconsideration (appeal) for health services
- The fast "expedited" grievance process is as follows:
 - You or an authorized representative can call, fax, or mail your complaint and mention that you want the fast complaint or expedited grievance process. Call the phone number, fax, or write your complaint and send it to the address listed in Chapter 2: *Phone numbers and resources (How to make a complaint about your medical care)*. The fastest way to submit a fast complaint is to call or fax us. The fastest way to file a grievance is to call us. When we receive your complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-calendar-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will investigate your complaint and notify you of our decision within 24 hours.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem that you want to complain about.

Step 2: We look into your complaint and give you our answer.

Chapter 7. If you have a problem or complaint (coverage decisions, appeals, complaints)

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
The Quality Improvement Organization is a group of practicing doctors and other health care professionals who are paid by the federal government to check and improve the care given to Medicare patients. **Appendix A** at the back of this document has the contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Aetna Medicare Eagle (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to [Medicare.gov/my/medicare-complaint](https://www.medicare.gov/my/medicare-complaint). You can also call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)). TTY/TDD users call [1-877-486-2048](tel:1-877-486-2048).

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Aetna Medicare Eagle (HMO-POS) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
 - Another Medicare health plan, with or without drug coverage,
 - Original Medicare *with* a separate Medicare drug plan,
 - Original Medicare *without* a separate Medicare drug plan.
- Your **membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Aetna Medicare Eagle (HMO-POS) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit [Medicare.gov](https://www.medicare.gov):

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage
- Original Medicare *with* a separate Medicare drug plan
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change your plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-833-570-6670 (TTY users call 711).**
- Find the information in the **Medicare & You 2027** handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Aetna Medicare Eagle (HMO-POS) when your new plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare <i>with</i> a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Aetna Medicare Eagle (HMO-POS) when your new drug plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	• Send us a written request to disenroll. Call Member Services at 1-833-570-6670 (TTY users call 711) if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Aetna Medicare Eagle (HMO-POS) when your coverage in Original Medicare starts.

Note: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items and services through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Aetna Medicare Eagle (HMO-POS) must end your plan membership in certain situations

Aetna Medicare Eagle (HMO-POS) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you're away from our service area for more than 12 months.
 - If you move or take a long trip, call Member Services at [1-833-570-6670](tel:1-833-570-6670) (TTY users call [711](tel:711)) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or national, or an eligible noncitizen.
- If you intentionally give us incorrect information when you're enrolling in our plan and that

information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Member Services at [1-833-570-6670](tel:1-833-570-6670) (TTY users call [711](tel:711)).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Aetna Medicare Eagle (HMO-POS) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)). TTY users call [1-877-486-2048](tel:1-877-486-2048).

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at [1-800-368-1019](tel:1-800-368-1019) (TTY [1-800-537-7697](tel:1-800-537-7697)) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at [HHS.gov/ocr/index.html](https://www.hhs.gov/ocr/index.html).

If you have a disability and need help with access to care, call us at Member Services at [1-833-570-6670](tel:1-833-570-6670) (TTY users call [711](tel:711)). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Aetna Medicare Eagle (HMO-POS), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First* (publication number 02179). You can get a copy by calling 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)), 24 hours a day, 7 days a week. TTY users should call [1-877-486-2048](tel:1-877-486-2048). Or you can download a copy by visiting the [Medicare.gov](https://www.Medicare.gov) website.

The Plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the federal statutes governing the Medicare Program. Your Medicare Advantage plan

coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers' compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your Medicare Advantage plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

As outlined herein, in these situations, your Medicare Advantage plan may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your Medicare Advantage plan shall be subrogated to stand in the place of all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your Medicare Advantage plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your Medicare Advantage plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your Medicare Advantage plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. Your Medicare Advantage plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your Medicare Advantage plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Medicare Advantage plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or

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obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your Medicare Advantage plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist your Medicare Advantage plan in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing the plan for benefits paid relating to the injury, illness or condition as well as for the plan's reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 4 Notice about recovery of overpayments

If the benefits paid by this *Evidence of Coverage*, plus the benefits paid by other plans, exceeds the total amount of expenses, Aetna has the right to recover the amount of that excess payment from among one or more of the following: (1) any person to or for whom such payments were made; (2) other Plans; or (3) any other entity to which such payments were made. This right of recovery will be exercised at Aetna's discretion. You shall execute any documents and cooperate with Aetna to secure its right to recover such overpayments, upon request by Aetna.

SECTION 5 National Coverage Determinations

Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2027, either Medicare or our plan will cover those services. When we receive coverage updates from Medicare, called National Coverage Determinations, we'll post the coverage updates on our website at [AetnaMedicare.com](https://www.aetna.com/medicare). You can also call Member Services to obtain the coverage updates that have been posted for the benefit year.

CHAPTER 10:

Definitions

Allowed Amount – The amount that providers are paid for covered services. The allowed amount is the amount that a network provider has agreed to accept as payment in full for services provided and is usually less than the provider's billed charges. For out-of-network providers, the allowed amount is the amount Original Medicare would pay for the services provided. Members may pay a portion of, or in some cases, all of the allowed amount if their deductible is not satisfied for the year, or if they have other share-of-cost such as coinsurance and/or copayments.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Aetna Medicare Eagle (HMO-POS), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to balance bill or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Calendar Year – A one year period between January 1 and December 31.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed copayment amount that a plan requires when a specific service is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service that a plan requires when a specific service is received.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan, providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Health Maintenance Organization (HMO) – A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Independent Practice Association (IPA) – An IPA, or Independent Practice Association, is an independent group of physicians and other health care providers under contract to provide services to members of managed care organizations (see Chapter 1, Section 6).

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

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Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs), Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Low Income Subsidy (LIS) – Go to Extra Help.

Maximum Charge – The maximum amount or limiting charge that a non-participating provider may charge a Medicare beneficiary for services billed on non-assigned claims.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services. Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Group – A Medical Group is a group of physicians and other health care providers under contract to provide services to members of our plan.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Aetna Medicare Eagle (HMO-POS) doesn't offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (member of our plan, or plan member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network – A group of doctors, hospitals, pharmacies, and other health care experts contracted by our plan to provide covered services to its members (go to Chapter 1, Section 3.2). Network providers are independent contractors and not agents of our plan.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Non-Medicare Covered Services – Services that are not normally covered when you have Original Medicare. These are usually extra benefits you may receive as a member of a Medicare Advantage plan.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Optional Supplemental Benefits – Non-Medicare covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Chapter 10. Definitions

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Point-of-Service (POS) – The POS benefit allows you to use a provider who is not in our network. However, if you choose to go out-of-network for your care, you will typically pay higher out-of-pocket expenses. While the POS options provide more choice and flexibility, it is important to remember that not all services are available outside the network of contracted providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care professionals who are paid by the federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

APPENDIX A:

Important contact information

Tennessee

State Health Insurance Assistance Program

Tennessee State Health Insurance Assistance Program (SHIP), Address: 1104 England Drive, Cookeville, TN 38501, **Phone:** [1-877-801-0044](tel:1-877-801-0044), **TTY:** [1-800-848-0299](tel:1-800-848-0299) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** tnmedicarehelp.com/?page_id=13327

Quality Improvement Organization

Acentra Health, Address: 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317, **Phone:** [1-888-317-0751](tel:1-888-317-0751), **TTY:** [711](tel:711), **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii–Aleutian time, **Website:** acentraqio.com

State Medicaid Office

TennCare Medicaid (Tennessee’s Medicaid program), Address: 310 Great Circle Road, Nashville, TN 37243, **Phone:** [1-855-259-0701](tel:1-855-259-0701) (Applications), [1-800-342-3145](tel:1-800-342-3145) (General), **TTY:** [1-877-779-3103](tel:1-877-779-3103) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, **Hours:** Monday–Friday 7:00 AM to 6:00 PM, **Website:** tn.gov/tenncare

Notice of Availability (NOA)

TTY: [711](tel: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)

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

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 કોલ 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):

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)

လၢကမၤန့ၢ် ကျိၣ်အတၢ်ဆိၣ်ထွဲမၤတၢ်မၤဒီး တၢ်န့ၢ်ဟူၣ် အပီးအလီၤ လၢအကြၢးအ ဘၣ်တဖၣ် ဒီးတၢ်မၤတၢ်မၤ လၢအဘျးအလဲတအိၣ်ဘၣ်တဖၣ်အဂီၢ်, ကိးလီတဲစိ နီၣ်ဂံၢ်အံၤ ဖဲ န ID ခးက့အပူၤတက့ၢ်. (Karen)

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

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

ເພື່ອເຂົ້າເຖິງການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ອຸປະກອນຊ່ວຍໃນການຟັງ ແລະ ການບໍລິການ ທີ່ເໝາະສົມໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍຕໍ່ທ່ານ, ໃຫ້ໃບຫາເບໃບບັດປະຈຳຕົວຂອງທ່ານ. (Laotian)

ដើម្បីទទួលបានសេវាជំនួយផ្នែកភាសា ព្រមទាំងឧបករណ៍ និងសេវាជំនួយបន្ថែមសមរម្យដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណ ID របស់អ្នក។ (Khmer)

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

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)

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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Aetna Medicare Eagle (HMO-POS) Member Services

Member Services – Contact Information

Call

1-833-570-6670 or the number on your member ID card
Calls to this number are free.
Hours of operation are 8 AM to 8 PM, 7 days a week.
Member Services at **1-833-570-6670** (TTY users call **711**) also has free language interpreter services available for non-English speakers.

TTY

711
Calls to this number are free.
Hours of operation are 8 AM to 8 PM, 7 days a week.

Fax

1-866-759-4415

Write

Aetna Medicare
PO Box 14088
Lexington, KY 40512

Website

Go to [AetnaMedicare.com/H3146-057](https://www.aetna.com/H3146-057) or scan this code with your smartphone to visit our website.



State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **Appendix A** at the back of this document.

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