January 1 – December 31, 2023

Evidence of Coverage:

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

This document gives you the details about your Medicare and Medicaid health care and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-866-409-1221. (TTY users should call 711). Hours are 8 AM to 8 PM, 7 days a week.

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

This document is available for free in Spanish. Este documento está disponible sin cargo en español.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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

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

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

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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Chapter 1:
Getting started as a member

SECTION 1 Introduction

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

You are covered by both Medicare and Medicaid:

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

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Aetna Medicare Assure Plus (HMO D-SNP). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

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

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

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

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

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

This *Evidence of Coverage* document tells you how to get your Medicare and Medicaid medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

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

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

If you are confused, concerned or just have a question, please contact Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in Aetna Medicare Assure Plus (HMO D-SNP) between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Aetna Medicare Assure Plus (HMO D-SNP) after December 31, 2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it
- -- *and* -- You are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan
Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources). To be eligible for our plan you must be eligible for both Medicare and certain levels of Medicaid: **QMB, QMB Plus, SLMB, SLMB Plus, FBDE, QDWI, QI**.

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

Section 2.2 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.
In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

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

Individuals that have Medicare, and qualify for full Medicaid benefits, but not the Medicare Savings Program are referred to as Full Benefit Dual Eligibles. Full benefit Medicaid coverage refers to the package of Medicaid services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals receive when they qualify under eligibility groups covered under a state's Medicaid program. Some of these coverage groups the states generally must cover (for example, supplemental security income (SSI) recipients) and some coverage groups the states have the option to cover (for example, the "special income level" group for institutionalized individuals, home and community based services (HCBS) programs participants, and "medically needy" individuals). Some of the services in the Medicaid benefit package are ones Medicare does not cover, such as certain long-term services and supports (LTSS), behavioral health, transportation, and vision services. Medicaid benefits vary by state. Full Benefit Dual Eligibles may or may not have to pay Medicare cost sharing for Medicare-covered care not included under their Medicaid plan unless the state chooses to pay these costs.

Section 2.3 Here is the plan service area for Aetna Medicare Assure Plus (HMO D-SNP)

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

Our service area includes these counties in:
Florida: Clay, Duval, Marion, St. Johns, St. Lucie.

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

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

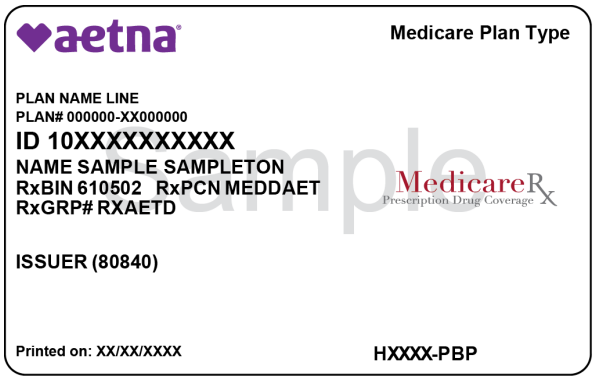
Section 2.4 U.S. Citizen or Lawful Presence

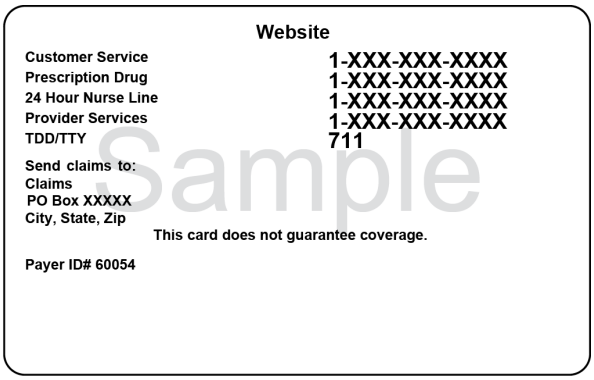
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Aetna Medicare Assure Plus (HMO D-SNP) if you are not eligible to remain a member on this basis. Aetna Medicare Assure Plus (HMO D-SNP)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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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





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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 The *Provider & Pharmacy Directory*

The *Provider & Pharmacy Directory* lists our network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. Our plan has a network of select providers to provide you with patient-centered care, coordinated services and enhanced provider communication. To locate a network provider you may contact Member Services or search the online provider directory. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Aetna Medicare Assure Plus (HMO D-SNP) authorizes use of out-of-network providers. We provide Medicaid health benefits under our plan's network of providers to members that are eligible for full Medicaid benefits.

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

The most recent list of providers and suppliers is available on our website at AetnaMedicare.com/findprovider.

If you don't have your copy of the *Provider & Pharmacy Directory*, you can request a copy from Member Services.

Section 3.3 The *Provider & Pharmacy Directory*

The *Provider & Pharmacy Directory* lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider & Pharmacy Directory* to find the network pharmacy that you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

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

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

The plan has a *List of Covered Drugs* (*Formulary*). We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Aetna Medicare Assure Plus (HMO D-SNP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Aetna Medicare Assure Plus (HMO D-SNP) Drug List.

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

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

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

Your costs may include the following:

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

In some situations, your plan premium could be less
The "Extra Help" program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage*** may not apply to you. We have sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Service and ask for the "LIS Rider."

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan Premium

As a member of Aetna Medicare Assure Plus (HMO D-SNP), you pay a monthly plan premium unless you qualify for "Extra Help" with your prescription drug costs. You may not pay a monthly plan premium (prescription drug plan premium) if you qualify for "Extra Help." People with Medicare and Medicaid automatically qualify for "Extra Help." For 2023, the monthly premium for Aetna Medicare Assure Plus (HMO D-SNP) is **$0** or up to **$22.30**.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums
In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most Aetna Medicare Assure Plus (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you are dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

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

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is $32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year,** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

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

Option 1: Paying by check
You may decide to pay your monthly premium to us by check using our invoice method. Please make your checks payable to our plan (which is on your invoice) not to CMS nor HHS. Monthly plan premium payments are due the 1st day of each month for coverage of the current month. We must receive your

check and corresponding month's invoice in our office by the 10th of each month to prevent your account from becoming delinquent. All monthly plan premium payments should be sent to the address listed on your payment invoice.

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

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

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

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

Option 4: Using your credit card or via e-check
You may pay your premium by using your credit card or checking account. You can do this by calling Member Services to make a payment over the phone. You may also set up a recurring payment online at www.AetnaMedicare.com/paybill. All premiums are due on the 1st of the month. If you pay using this option, you will select the date and amount of the payment and will continue to receive a monthly invoice.

Option 5: Having your premium taken out of your monthly Social Security check.
You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up.

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

What to do if you are having trouble paying your plan premium

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium.

Section 5.2 Can we change your monthly plan premium during the year?

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

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Member Services.

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

SECTION 7 How other insurance works with our plan

Other insurance
Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical, or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. 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 is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

Chapter 2:
Important phone numbers and resources

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

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

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

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

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

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

Method	Appeals for Medical Care – Contact Information
CALL	1-866-409-1221 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.

Method	Appeals for Medical Care – Contact Information
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 Assure Plus (HMO D-SNP) Aetna Medicare Part C Appeals PO Box 14067 Lexington, KY 40512
WEBSITE	aetnamedicare.com/plan_choices/advantage_appeals_grievances.jsp

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-866-241-0357 Calls to this number are free. Hours of operation are 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. Hours of operation are 24 hours a day, 7 days a week.
FAX	1-724-741-4954
WRITE	Aetna Medicare Assure Plus (HMO D-SNP) Aetna Medicare Part D Appeals PO Box 14579 Lexington, KY 40512
WEBSITE	aetnamedicare.com/plan_choices/advantage_appeals_grievances.jsp

How to contact us when you are making a complaint about your medical care
You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

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

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay to the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services* or drugs).

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

Method	Payment Requests for Medical Coverage – Contact Information
FAX	1-866-474-4040
WRITE	Aetna Medicare PO Box 981106 El Paso, TX 79998-1106
WEBSITE	AetnaMedicare.com
Method	**Payment Requests for Part D Prescription Drugs – Contact Information**
WRITE	Aetna Medicare Aetna Pharmacy Management PO Box 52446 Phoenix, AZ 85072-2446
WEBSITE	AetnaMedicare.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Aetna Medicare Assure Plus (HMO D-SNP): • **Tell Medicare about your complaint:** You can submit a complaint about Aetna Medicare Assure Plus (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on **"Talk to Someone"** in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

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

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

You should contact the QIO in any of these situations:

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

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.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.

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

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

If you have questions about the assistance you get from Medicaid, contact the Florida Agency for Health Care Administration, Division of Medicaid.

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

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

Refer to **Addendum A** of this document for the name and contact information for the Florida Agency for

Health Care Administration, Division of Medicaid and Ombudsman programs in your state.

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

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

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

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

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

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (See **Addendum A** of this document for contact information).

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

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

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

from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the ADAP in your state (telephone numbers are in **Addendum A** at the back of this document). **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP contact. (Refer to **Addendum A** at the back of this document for the name and contact information of the ADAP in your state).

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

Chapter 3:
Using the plan for your medical and other covered services

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

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

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

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

- ***"Providers"*** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- ***"Network providers"*** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for covered services.
- ***"Covered services"*** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

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

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive 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) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about

this, see Section 2.3 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions*:
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Prior authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for dialysis may be higher.

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

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your 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 & Pharmacy Directory* or go to our website at AetnaMedicare.com/findprovider for a complete listing of PCPs in your area.

What is the role of a PCP in coordinating covered services?
Your PCP will provide most of your care, and when you need more specialized services, they will coordinate 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. Certain types of covered services may require a referral from your PCP.

What is the role of the PCP in making decisions about or obtaining prior authorization?
In some cases, your PCP or other provider or you as the enrollee (member) of the plan may need to get approval in advance from our Medical Management Department for certain types of services or tests (this is called getting "prior authorization"). Obtaining prior authorization is the responsibility of the PCP, treating provider, or you as the member. Services and items requiring prior authorization are listed in Chapter 4.

How do you choose your PCP?
You can select your PCP by using the *Provider & Pharmacy Directory,* by accessing our website at AetnaMedicare.com/findprovider, or getting help from Member Services.

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

If there is a particular plan specialist or hospital that you want to use, check first to be sure that your PCP makes referrals to that specialist, or uses that hospital.

Changing your PCP
You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. 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.
They will also send you a new membership card that shows the name and/or phone number of your new PCP.

Section 2.2 What kinds of medical care and other services you can get without a referral from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

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

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

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

What is the role of the PCP in referring members to specialists and other providers?
Our plan has a network of select providers to provide you with patient-centered care, coordinated services and enhanced provider communication. To locate a network provider you may contact Member Services or search the online provider directory.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member.

If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). If you use a PCP whose name is not printed on your member ID card or see a specialist without a referral, you may incur a higher cost share or your claims may be denied. For more details about which services require a referral from your PCP, please contact us.

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 *Medical Benefits Chart* in Chapter 4, Section 2.1.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. A prior authorization may be required in this situation.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

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

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior authorization should be obtained from the plan prior to seeking care. In this situation, if the care is approved, you would pay the same as you would pay if you got the care from a network provider. Your PCP or other network provider will contact us to obtain authorization for you to see an out-of-network provider.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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

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

Section 3.1 Getting care if you have a medical emergency

What is a *"medical emergency"* and what should you do if you have one?
A ***"medical emergency"*** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or loss of function of a limb, or loss of 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.

If you have a medical emergency:

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

What is covered if you have a medical emergency?
Our plan covers worldwide services outside of the United States under the following circumstances:

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

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the Medical Benefits Chart in Chapter 4 for more information. Be sure to get a copy of all your medical records from your emergency or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim.
Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your 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 will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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

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

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

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

What are "urgently needed services"?
An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out-of-network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

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

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

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the Medical Benefits Chart in Chapter 4 for more information. Be sure to get a copy of all your medical records from your emergency or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim.

Section 3.3 Getting care during a disaster

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

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

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from

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

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

Section 4.1 You can ask us to pay our share of the cost for covered services

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

Section 4.2 What should you do if services are not covered by our plan?

Aetna Medicare Assure Plus (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services. Before paying for the cost of the service, contact Member Services to find out if the service is covered.

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

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

Section 5.1 What is a "clinical research study"?

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you are paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to get

approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

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

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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

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

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

After Medicare has paid 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 will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

> *Here's an example of how the cost-sharing works*: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

Do you want to know more?
You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call

1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

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

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

owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Aetna Medicare Assure Plus (HMO D-SNP) under certain limited circumstances, we will transfer ownership of the DME item to you. Call Member Services for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?
If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer payments for the DME item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?
If you qualify for Medicare oxygen equipment coverage Aetna Medicare Assure Plus (HMO D-SNP) will cover:

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

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

What happens if you leave your plan and return to Original Medicare?
Original Medicare requires an oxygen supplier to provide you service for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

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

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

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

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

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

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

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is **$3,450**.

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$3,450**, you will not have to pay any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay for your plan premiums and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of Aetna Medicare Assure Plus (HMO D-SNP), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add 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 is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

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

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

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

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

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, equipment, and Part B prescription 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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the

plan's network. This is called giving you a "referral."
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance to be covered as in-network services are marked by a note in the Medical Benefits Chart.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including payments of Medicare Parts A & B premiums, deductibles, coinsurance and copayments (except for Medicare Part D) depending on your Medical Savings Program eligibility. Medicaid may also cover services that Medicare does not cover, like additional home health services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- Under our plan, if you are eligible for full Medicaid, we will provide coverage for some Medicaid benefits as required in our plan's agreement with your State Medicaid Agency. The benefits chart in Chapter 4 states what benefits are covered under the plan. The benefits chart will also state any benefit limitations or authorizations that apply.
- If you are within our plan's 6-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan covered Medicare benefits. We will also continue to cover the Medicaid benefits that are covered by your plan. You will fall into the deeming period if you lose your Medicaid eligibility or your Medicare Savings Program eligibility. The deeming period begins the first day of the month after you lose your dual eligible status. When you are in the period of deemed continued eligibility, you are still a member of Aetna Medicare Assure Plus (HMO D-SNP). However, during this period, you might be responsible for some out-of-pocket costs that were previously paid for by your Medicaid benefits.

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

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

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

OR

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

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

- Because Aetna Medicare Assure Plus (HMO D-SNP) participates in the Part D reduction program that offers benefits to help support your healthcare needs, you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - If you are unable to make decisions for yourself in the future about your health care, medical professionals can make sure your wishes are followed. Advance care planning means having conversations and making decisions about the care you would like in the future.
  - We will assist you with the necessary forms that you need to give someone the legal authority to make medical decisions for you if you ever become unable to make them for yourself.
- You may get advance care planning assistance by contacting the Care Team at 1-866-409-1221.
- WHP and ACP are voluntary and you are free to decline these services.

Important Benefit Information for Enrollees Who Qualify for "Extra Help":

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

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

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 physician (PCP) or specialist and get more than one covered service during the single visit: *A clinic visit cost share may apply based on the role of the attending physician (PCP or specialist).*	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services **and** the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

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

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	$0 copay for each Medicare-covered acupuncture visit. $0 copay for each non-Medicare covered additional acupuncture visit.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. **Additional acupuncture services** In addition to Medicare-covered benefits, we also offer: • Acupuncture services to treat conditions in addition to chronic lower back pain: up to twenty four visits every year***** We have partnered with American Specialty Health (ASH) to provide your acupuncture coverage. Covered services must be performed by a licensed acupuncturist for the relief of musculoskeletal pain conditions, nausea from pregnancy, immediate post-surgery, and chemotherapy. On your initial visit, your provider will discuss and establish your treatment plan. Establishing medical necessity is the responsibility of ASH and your provider. To locate a network provider, you may contact Member Services or search our online directory and look for the American Specialty Health (ASH) designation. If you choose to use a provider outside of our network, the services you receive will not be covered. Covered services do not include acupuncture for: • Weight loss • Sexual dysfunction • Mental conditions such as depression, smoking	

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
cessation, or drug or alcohol addiction • Any other conditions that do not meet coverage criteria	
Allergy services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include services that provide diagnostic and therapeutic procedures relating to hypersensitivity disorders that may be manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body. Covered medically necessary services include: Allergy testing as follows: • In vitro specific IgE tests • Intracutaneous skin tests • Percutaneous skin tests • Ingestion challenge testing Allergen immunotherapy as follows: • Up to 156 doses every 366 days • Up to 52 doses every 366 days **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$0 - $100 copay for each Medicare-covered one-way trip via ground ambulance. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • $100 copay for SLMB, QI, and QDWI members $0 - 20% coinsurance for each Medicare-covered one-way trip via air ambulance.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Prior authorization is required for non-emergency transportation by fixed-wing aircraft. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	• $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members Ground or air ambulance cost-sharing is not waived if you are admitted to the hospital.
Anesthesia services (Medicaid) Additional services may be available under the Medicaid portion of the plan's benefits. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" preventive visit. You may schedule your annual routine physical once each calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. Please see ***"Outpatient diagnostic tests and therapeutic services and supplies"*** for more information.	$0 copay for an annual routine physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year. **Note:** Your first annual wellness visit can't take place within 12	There is no coinsurance, copayment, or deductible for the annual wellness visit.

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

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

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

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

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
health therapy provides services to the recipients, their families, or other responsible persons to improve the symptoms of the recipient's mental health or substance use disorder(s) using evidence-based, insight-oriented, therapeutic interventions. **Prior authorization may be required.**	
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms. $0 copay for each diagnostic mammogram.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered cardiac rehabilitation service. $0 copay for each Medicare-covered intensive cardiac rehabilitation service.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate),	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
check your blood pressure, and give you tips to make sure you're eating healthy. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Child health services targeted case management (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Targeted case management services are available to members in gaining access to needed medical, social, educational, and other services. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation In addition to Medicare-covered benefits, we also offer:	$0 copay for each Medicare-covered chiropractic visit. $0 copay for each non-Medicare covered additional chiropractic visit.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Additional chiropractic services: up to twelve visits every year Services include, but are not limited to, evaluation and management, x-ray examination, chiropractic manipulative therapy, modalities and therapeutic procedures, physical rehabilitation for musculoskeletal conditions of the spine and extremities. To locate a network provider, you may contact Member Services or search our online directory. If you choose to use a provider outside of the network, the services you receive will not be covered. **Prior authorization may be required and is the responsibility of your provider.**	
Chiropractic services (Medicaid) Additional services available under the Medicaid portion of the plan's benefits include: Medically necessary chiropractic services: • Up to 24 visits per year, per member • X-rays	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months Two of each of the following per calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered screening barium enema. If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology will be covered at $0 copay as these procedures were performed during a preventive service.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	Diagnostic colonoscopy is covered at $0 copay when you schedule a diagnostic colonoscopy after having a Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT). If you have had polyps removed during a previous colonoscopy or have a condition that is monitored via colonoscopy (such as a prior history of colon cancer), ongoing colonoscopies are considered diagnostic, and are subject to the outpatient surgery cost-sharing. (See ***"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"*** for more information.)
Companion care Our plan has partnered with "Papa, Inc." to provide in-person (or virtual) assistance and companionship. Papa connects you with an adult companion who can provide an extra set of hands, a shoulder to lean on, a listening ear — when, where and how you need it, to help you maintain your health. You can decide how to use this benefit by working with your care manager or health care provider to best meet your needs. You can use the companion for company, or for help with activities around the house such as light cleaning, meal preparation and laundry. The companion can also assist with grocery shopping, light errands, help with electronics such as your computer or phone, or can even play cards with you. You may schedule up to 120 hours of service per year. You can also work with your care manager or physician on how to best utilize this benefit to help you maintain your health. To schedule a Papa visit, or if you have questions on this benefit, please call (800) 467-3535.	There is no coinsurance, copayment, or deductible for this supplemental benefit.
Dental services (additional) In general, preventive dental services (such as cleaning,	Non-Medicare covered preventive dental services:

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Preventive dental services ◦ Oral exams***** ◦ Cleanings***** ◦ Fluoride treatments***** ◦ Dental x-rays***** • Comprehensive dental services ◦ Non-routine services***** ◦ Diagnostic services***** ◦ Restorative services***** ◦ Endodontics services***** ◦ Periodontics services***** ◦ Extractions***** ◦ Prosthodontics and maxillofacial services***** Our plan partners with Liberty Dental to provide your dental benefits. Please note that some services require authorization prior to treatment. These prior authorizations are clinically reviewed to determine if the requested services are necessary and appropriate based upon industry standards and Liberty clinical guidelines. If the prior authorization is denied, the service will not be covered and you will be responsible for all associated costs. To locate a network provider, you may call Member Services at (866) 610-0282 or search the Liberty Dental online provider directory at libertydentalplan.com/AetnaMedicare. If you choose to use a provider outside of the network, the services you receive will not be covered.	• Oral exams: $0 copay (see schedule of benefits) • Cleanings: $0 copay (two visits every year) • Fluoride treatments: $0 copay (one visit every six months) • Dental x-rays: $0 copay (see schedule of benefits) Non-Medicare covered comprehensive dental services: • Non-routine services: $0 copay (see schedule of benefits) • Diagnostic services: $0 copay (see schedule of benefits) • Restorative services: $0 copay (see schedule of benefits) • Endodontics: $0 copay (see schedule of benefits) • Periodontal services: $0 copay (see schedule of benefits) • Extractions: $0 copay (see schedule of benefits) • Prosthodontics and maxillofacial services: $0 copay (see schedule of benefits) See the **"Schedule of Benefits"** following this chart for more information about non-Medicare covered dental services. (See **"Physician/Practitioner services, including doctor's office visits"** for information about Medicare-covered dental services.)
Dental services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary dental services as follows:	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Adjunctive General Services: • Behavioral management when provided in connection with a covered dental service • Intravenous/Non-Intravenous Sedation up to three times Diagnostic Services: • Oral Evaluations • Comprehensive evaluation every three years • Limited evaluations, as medically indicated Diagnostic Imaging: • One complete series of intraoral radiographs every three years • One panoramic radiograph every three years Prosthodontics Services: Prosthodontics services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows: • One of the following: ◦ One upper set ◦ One lower set ◦ One complete set of full dentures ◦ Removable partial dentures • One reline, per denture, per 366 days Additional general, diagnostic, endodontic, orthodontic, periodontal, and preventive services may be available to members under the age of 21. **Prior authorization may be required**.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Notes:** • We cover diabetic supplies made by OneTouch/LifeScan. We exclusively cover OneTouch/LifeScan glucose monitors and test strips. We also cover OneTouch/LifeScan lancets, solutions and lancing devices. You should order your LifeScan starter kit, including the model of meter you prefer, by contacting LifeScan directly at 1-877-764-5390. Use	0% coinsurance for each Medicare-covered supply to monitor blood glucose. $0 copay for Medicare-covered diabetic shoes and inserts. $0 copay for Medicare-covered diabetes self-management training.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
order code: 123AET200. LifeScan will send you a starter kit in the mail that includes the meter you selected, a small supply of lancets and test strips, as well as usage and educational materials. You should also reach out to your physician to obtain a prescription for LifeScan test strips that you can fill at your network pharmacy. • We do not cover other brands of monitors and test strips unless you or your provider requests a medical exception and it is approved. If the medical exception is approved, a 0% coinsurance will apply. • Non-LifeScan monitors and test strips without a medical exception, or a medical exception that is not approved, will not be covered. • Continuous Glucose Monitors (CGMs) are considered Durable Medical Equipment (DME) and are subject to applicable DME cost sharing. **Prior authorization is required for more than one blood glucose monitor per year and/or test strips in excess of 100 strips per 30 days.** **Prior authorization may be required for diabetic shoes and inserts.** **Prior authorization is the responsibility of your provider.**	
Dialysis Services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services for Hemodialysis and Peritoneal dialysis treatments. Medicaid covered services include: • All supervision and management of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions), and all necessary training and monitoring for recipients receiving peritoneal dialysis treatment.	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• 500 units (500,000 injectable units) of Erythropoietin (EPO, Epogen) per month. **Prior authorization may be required.**	
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at: AetnaMedicare.com/findprovider. Home infusion drugs: Home infusion drugs that are processed under your medical benefits***** **Prior authorization may be required and is the responsibility of your provider.** Additional services may be available under the Medicaid portion of the plan's benefits, including, but not limited to, specialized medical equipment and supplies (e.g., incontinence supplies) to enrollees with a diagnosis of AIDS. **Prior authorization may be required.**	$0 copay for each Medicare-covered durable medical equipment item. $0 copay for covered home infusion drugs that are processed under your medical benefits.
Early intervention services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Early intervention services (EIS) provide early identification and treatment of recipients under the age of three years (36 months) with developmental delays or related conditions.	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Prior authorization may be required.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are 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 is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. In addition to Medicare-covered benefits, we also offer: • Emergency care (worldwide) • Emergency ambulance services (worldwide)	$0 - $120 copay for emergency care. Cost-sharing is waived if you are admitted to the hospital within 24 hours. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • $120 copay for SLMB, QI, and QDWI members $0 copay for emergency care worldwide (i.e., outside the United States). $0 copay for one-way emergency ambulance services worldwide (i.e., outside the United States). If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.
Extra benefits card You will receive a $480 quarterly allowance on a preloaded debit card to be used towards the following: • **Healthy foods** ◦ Benefit can be used towards the purchase of healthy and	There is no coinsurance, copayment, or deductible for the extra benefits card.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
nutritious foods and produce. Approved items can be purchased at approved retail locations as well as online at Aetna.NationsBenefits.com and over the phone at 1-877-204-1817 (TTY: 711). For a complete list of covered items or approved retail locations, you may visit Aetna.NationsBenefits.com or use the Nations mobile app. Approved food items are healthy options and will be allowed for retail purchases using your preloaded debit card at the register if they are a plan-approved item. Please see your member materials for more information on items that you will be able to purchase. • **Utilities** ◦ Benefit can be used towards your utility expenses such as water, heating oil, electricity, sanitary/trash, gas, land line or cell phone, and internet. The card must be presented at the utilities provider or you may call the utilities provider for payment. • **Transportation** ◦ Benefit can be used for transportation services including any cost share you may have for emergency transport. Approved transportation expenses include: ambulance services (if applicable), taxi, rideshare services (including Uber and Lyft), public transportation (including bus and metro), and gas (petroleum). Your allowance is quarterly and any unused funds will not roll over and will be forfeited. The debit card will be provided by mail. Please call NationsBenefits Member Experience Advisor 1-877-204-1817 (TTY: 711), 24 hours a day, 7 days a week for more information on this benefit.	
Fall prevention Our plan provides you with a $150 allowance every year for purchasing certain clinically appropriate home and bathroom safety devices that can help you manage physical impairments and improve your ability to move safely around your home. Please call the number on your Member ID card if you have questions about these safety items or to learn more about this	There is no coinsurance, copayment, or deductible for certain clinically appropriate home and bathroom safety devices.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
benefit. Covered items will be shipped directly to you. You will be responsible for installation and assembly. There is a limit of 3 orders per year, even if you have not exceeded the annual allowance.	
Fitness Program (Physical fitness) You are covered for a basic membership to any SilverSneakers® participating fitness facility. At-home fitness kits and online classes are also available if you do not reside near a participating club or prefer to exercise at home. You may order one fitness kit per year through SilverSneakers. You will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self help, and staying connected. These classes can be accessed online by visiting SilverSneakers.com. To get started, you will need your SilverSneakers ID number. Please visit SilverSneakers.com or call SilverSneakers at 1-888-423-4632 (TTY/TDD: 711) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers.	$0 copay for health club membership/fitness classes.
Gastrointestinal services (Medicaid) Additional coverage under the Medicaid portion of the plans benefits include medically necessary services that provide diagnostic and therapeutic procedures relating to digestive disorders. Covered medically necessary services include: • Restrictive bariatric surgeries that shrink the size of the stomach reducing the amount of food that it can hold;	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Malabsorptive bariatric surgeries that rearrange and/or remove part the digestive system limiting the amount of calories and nutrients that can be absorbed; • Combination bariatric surgeries that combine both restrictive and malabsorptive techniques; • Bariatric surgery revisions, reversals or conversions for complications related to the surgery; • Gastroenterology; • Gastric Physiology **Prior authorization may be required.**	
Genitourinary services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services that provide diagnostic and therapeutic procedures relating to genital and urinary disorders. Covered medically necessary services include: • Endocrine surgical services; • Endocrinology; • Female genital surgical services; • Male genital surgical services • Urinary surgical services **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Health and wellness education programs • **Health education:** Members are eligible to receive the health education supplemental benefit to support a healthier lifestyle. This benefit gives members the opportunity to interact as a group, one-on-one, or virtually, with a certified health educator or other qualified health professional. Members may receive educational supplies such as books and pamphlets to augment their interactive sessions. In addition, members	$0 copay for health education. $0 copay for 24-Hour Nurse Line services.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
will be encouraged to adopt healthy habits and build skills to enhance self-care capabilities. • **24-Hour Nurse Line:** Talk to a registered nurse 24 hours a day, 7 days a week. Please call 1-855-493-7019 (For TTY/TDD assistance, please dial 711).	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. In addition to Medicare-covered benefits, we also offer: • Routine hearing exams: one exam every year • Hearing aid fitting/evaluation: one hearing aid fitting/evaluation every year • Hearing aids: two hearing aids every year***** **Non-Medicare covered hearing aid maximum benefit:** Plan pays up to $2,500 per ear for hearing aids every year. You are responsible for any amount above the hearing aid coverage limit. Our plan partners with NationsHearing to provide your hearing exam and hearing aid benefit. All appointments for hearing exams and hearing aids must be scheduled through NationsHearing by calling 1-877-225-0137. If you choose to schedule an appointment directly with a provider, your services will not be covered. Additionally, to be covered, all hearing aids must be purchased through NationsHearing.	$0 copay for each Medicare-covered hearing exam. $0 copay for each non-Medicare covered routine hearing exam. $0 copay for each non-Medicare covered hearing aid fitting/evaluation. Hearing aids: • $0 copay (two hearing aids every year)
Hearing services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services that provide screening, assessment and testing services, and appropriate hearing devices to members in order to detect and mitigate the impact of hearing loss.	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Covered medically necessary services include: • Diagnostic Audiological Tests • Cochlear Implants • Hearing aids ◦ One new complete hearing aid device per ear, every three years ◦ Up to three pairs of ear molds per year ◦ One fitting and dispensing service per ear • Repair and replacement of hearing devices ◦ Repairs and replacement of both Medicaid and non-Medicaid provided hearing aids ◦ Up to two hearing aid repairs every 366 days, after the one year warranty period has expired ◦ Bone anchored hearing aid external components and cochlear implant components, including batteries, after the manufacturer's warranty or insurance protection plan coverage period has expired	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health	$0 copay for each Medicare-covered home health service. $0 copay for each Medicare-covered durable medical equipment item.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
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 health services (Medicaid) Additional coverage under the Medicaid portion of the plans benefits include medically necessary services that provide home health visits that provide medically necessary skilled nursing and home health aide services to members whose medical condition, illness, or injury requires the care to be delivered in their home or in the community. Covered medically necessary services include: • Up to four intermittent home health visits, per day, for members under the age of 21 years • Up to three intermittent home health visits, per day, for members age 21 years and older	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan. Covered services include, but are not limited to:	You will pay the cost-sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. (See **"Physician/Practitioner Services, Including Doctor's Office Visits"** or **"Home Health Agency Care"** for any applicable cost-sharing.) Please note that home infusion drugs,

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	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 are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis</u>: Original Medicare (rather than our plan) will pay for your hospice services related to your terminal diagnosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis</u>: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Aetna Medicare Assure Plus (HMO D-SNP). Hospice consultations are included as part of inpatient hospital care. Physician service cost-sharing may apply for outpatient consultations.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by Aetna Medicare Assure Plus (HMO D-SNP) but are not covered by Medicare Part A or B: Aetna Medicare Assure Plus (HMO D-SNP) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 *(What if you're in Medicare-certified hospice?).* **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. $0 - 20% coinsurance for all other

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	vaccines covered under Medicare Part B. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Days covered: There is no limit to the number of days covered by our plan. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs	$0 per stay for each medically necessary covered inpatient stay. Cost-sharing is charged for each medically necessary covered inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities, is considered a new admission. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• 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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Aetna Medicare Assure Plus (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization may be required and is the responsibility**	

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

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

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 copay for each Medicare-covered x-ray. $0 copay for each Medicare-covered therapeutic radiology service. $0 copay for Medicare-covered medical supplies. $0 copay for each Medicare-covered prosthetic device. $0 copay for each Medicare-covered physical and speech therapy service. $0 copay for each Medicare-covered occupational therapy service.
Integumentary services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary integumentary services that provide diagnostic and therapeutic procedures relating to disorders of the skin and associated structures. Medically necessary services may include: • Active wound care management • Dermatological procedures • Integumentary surgical services including: ◦ Breast reconstruction ◦ Gynecomastia surgery ◦ Reduction Mammoplasty **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Meal benefit	$0 copay for covered meals.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
After discharge from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to your home, you may be eligible to receive up to 42 meals over a 14-day period* delivered to your home. After our plan confirms that this benefit will help support your recovery or manage your health conditions, and is not based solely on convenience or comfort purposes, you will be contacted by our partner, Independent Living Systems, to schedule delivery. **Note:** Observation stays do not qualify you for this benefit.	
Medical foster care services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. Medical Foster Care Services provide care to recipients with complex medical needs to enable them to live in a foster care home. **Prior authorization may be required**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Medical massage therapy (Medicaid) Medically necessary massage therapy services may be available under the Medicaid portion of the plan's benefits to enrollees diagnosed with AIDS, and who have had a history of an AIDS-related opportunistic infection for the treatment of peripheral neuropathy or severe neuromuscular pain and lymphedema by medical massage. **Prior authorization may be required and the health plan may limit medical massage services based on medical necessity.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. $0 copay for each additional session of medical nutrition therapy.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
services and renew their order yearly if your treatment is needed into the next calendar year. In addition to Medicare-covered benefits, we also offer: • Additional sessions of medical nutrition therapy: unlimited visits every year for Medicare-covered and non-Medicare covered diseases.	
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens	$0 - 20% coinsurance for chemotherapy drugs. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members $0 - 20% coinsurance for all other drugs covered under Medicare Part B. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members Part B drugs may be subject to step therapy requirements.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: Aetna.com/PartB-Step We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. **Prior authorization may be required and is the responsibility of your provider.**	
Mental health targeted case management (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary mental health targeted case management services that provide assistance to members in gaining access to needed medical, social, educational, and other services. **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Neurology services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include neurology services that provide diagnosis and treatment of diseases and disorders of the nervous system. Covered medically necessary services include: • Autonomic function testing • Electrooculogram • Electrodiagnostics, including nerve conduction studies	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
and electromyography • Electroencephalograph for sleep studies and seizure activity • Evoked potentials and reflex tests • Intrathecal baclofen therapy pump placement, removal, or revision • Muscle and range of motion testing • Muscle testing and guidance for chemodevervation • Polysomnography and sleep studies indicated for the following: ◦ Diagnosis of sleep related breathing disorders ◦ Continuous Positive Airway Pressure titration in recipient's sleep related breathing disorders ◦ Documenting the presence of obstructive sleep apnea prior to surgical interventions ◦ Assessment of treatment results in some cases, with a multiple sleep latency test in the evaluation of suspected narcolepsy ◦ Evaluating sleep related behaviors that are injurious, and in certain atypical or unusual parasomnias • Up to two nerve conduction velocity (NCV) studies for polyneuropathy in diabetes per year, per recipient • Vagus nerve stimulator (VNS) placement, removal, or revision for intractable epilepsy **Prior authorization is required.**	
Nursing facility (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include nursing facility services not covered by your Medicare benefits as follows: • Covered for members under the age of 18 • For members over the age of 18, nursing facility services are covered in the following circumstances: ◦ For up to one-hundred twenty (120) days from the date of the most recent nursing facility admission, regardless of payer, when:	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
◦ The enrollee is in need of long-term nursing facility services; ◦ The enrollee has completed all Preadmission Screening and Resident Review (PASRR) requirements; ◦ DCF has determined the enrollee is eligible for Institutional Care Program (ICP) Medicaid; and ◦ The member is not yet enrolled in the Medicaid Long Term Care Program **Prior authorization may be required and is the responsibility of your provider.**	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist 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**	$0 copay for each Medicare-covered opioid use disorder treatment service.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
of your provider.	
Oral and maxillofacial surgery (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary surgery services to treat diseases, defects and injuries. Covered medically necessary services include: • Biopsies • Bone, tissue, and cartilage grafts • Consultations • Debridement • Endosteal implants when used in conjunction with reconstructive surgeries • Evaluation and management • Excisions • Impressions and custom preparation of prosthesis • Moderate sedation • Open and closed treatment of fractures • Repair and destruction of lesions • Reconstructions • Radiology procedures • Surgical procedures essential to the preparation of the mouth for dentures • Tissue repair **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Orthopedic services (Medicaid) Additional medically necessary orthopedic services may be available under the Medicaid portion of the plan's benefits including procedures for the correction or prevention of deformities, disorders, and injuries of the skeleton and associated structures. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:	$0 copay for each Medicare-covered x-ray.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• X-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 begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered therapeutic radiology service. $0 copay for Medicare-covered medical supplies. $0 copay for each Medicare-covered lab service. $0 copay for Medicare-covered and non-Medicare covered blood services. $0 copay for each Medicare-covered CT scan. $0 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 copay for each Medicare-covered diagnostic procedure and test. 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 the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as	$0 copay for outpatient hospital observation services.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
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 are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at	$0 - $120 copay for emergency care. Cost-sharing is waived if you are admitted to the hospital within 24 hours. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • $120 copay for SLMB, QI, and QDWI members $0 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. $0 copay for outpatient hospital observation services. $0 copay for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered lab service. $0 copay for each Medicare-covered CT scan.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered diagnostic radiology service other than CT scans. $0 copay for each Medicare-covered x-ray. $0 copay for each Medicare-covered therapeutic radiology service. $0 copay for each Medicare-covered individual session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered individual session for outpatient mental health services provided by a mental health professional other than a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a mental health professional other than a psychiatrist. $0 copay for each Medicare-covered partial hospitalization day. $0 copay for Medicare-covered medical supplies. $0 - 20% coinsurance for chemotherapy drugs.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
	• $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members $0 - 20% coinsurance for all other drugs covered under Medicare Part B. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered individual session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a psychiatrist. $0 copay for each Medicare-covered individual session for outpatient mental health services provided by a mental health professional other than a psychiatrist. $0 copay for each Medicare-covered group session for outpatient mental health services provided by a mental health professional other than a psychiatrist.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy.	$0 copay for each Medicare-covered occupational therapy service. $0 copay for each Medicare-covered

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	physical and speech therapy service.
Outpatient substance abuse services Our coverage is the same as Original Medicare's which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment. • Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered individual outpatient substance abuse session. $0 copay for each Medicare-covered group outpatient substance abuse session.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to	$0 copay for each Medicare-covered outpatient surgery at an outpatient hospital facility. $0 copay for each Medicare-covered outpatient surgery at an ambulatory

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	surgical center.
Over-the-Counter (OTC) items You will receive a $240 quarterly allowance on a preloaded debit card to be used towards the following: Over-the-counter items: The purchase of covered plan-approved OTC items purchased either through mail order or in a participating retail store using a preloaded debit card. Mail order items are shipped directly to your home with 2-day shipping. If your purchase exceeds your available balance, you may use an alternative form of payment to pay for the remaining purchase balance. For a complete list of covered items, please refer to the NationsOTC catalog or you can look up items online or through the NationsBenefits mobile application. Approved OTC items are wellness-related and will be allowed for retail purchase using your preloaded debit card at the register if they are a plan-approved item. Reimbursement for the purchase of OTC items is based on submitted receipts and allowed only in the situation where the debit card is not working correctly due to a technical issue during the card swipe. Please submit a completed reimbursement form and upload supporting receipts online at Aetna.NationsBenefits.com or call NationsBenefits at 1-877-204-1817 (TTY: 711) to speak with a Member Experience Advisor for more information. Only eligible items will be considered for reimbursement. Your allowance is quarterly and any unused funds will not roll	There is no coinsurance, copayment, or deductible for covered OTC items. This benefit includes certain nicotine replacement therapies.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
over and will be forfeited. The debit card will be provided by mail. Note: Your separate OTC allowance is in addition to the allowance on your Extra Benefits card and will be on the same preloaded debit card. Both allowances will be tracked separately for you. OTC Vendor: Nations NationsBenefits OTC coverage includes approved OTC items and products, shipped directly to your home in two business days. Orders can be placed 24 hours a day, 7 days a week, in the following ways: • Online – Visit aetna.nationsbenefits.com. • By Phone – Call a Nations OTC Member Experience Advisor at 1-877-204-1817 (TTY: 711), 24 hours a day, 7 days a week. • By Mail – Fill out and return the order form in the product catalog. • Retail – Visit participating retail locations and purchase approved items. Ordered items are for enrollees only. You can visit aetna.nationsbenefits.com or use the NationsBenefits mobile application to identify participating retail locations and eligible items for purchase.	
Pain management (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services for the treatment of pain using nerve blocks or steroid injections. Covered medically necessary services include: • Up to 12 facet joint injections, with or without steroids, performed under fluoroscopic guidance for the treatment of acute and chronic neck and low back pain in a six month period, per recipient, for the following: ◦ Diagnostic trial to determine the origin of pain ◦ Therapeutic injection when conservative treatment (oral medications, rest and limited activity, or physical therapy) has failed	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Up to four percutaneous radiofrequency neurolysis for long-term pain relief in a four month period, per recipient, when all of the following are met: ◦ Low back or neck pain is suggestive of facet joint origin as documented in the recipient's history, physical and radiographic evaluations ◦ Pain has failed to respond to conservative management (oral nonsteroidal anti-inflammatory medications, rest and limited activity, or physical therapy) as documented in the medical record ◦ A diagnostic temporary block and injections with local anesthetic of the facet nerve (medial branch block) under fluoroscopic guidance into the facet joint has resulted in at least fifty percent reduction in pain ◦ A minimum of six months has elapsed since prior percutaneous radiofrequency neurolysis treatment • Neuroplasty **Prior authorization is required.**	
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Prior authorization may be required and is the responsibility of your provider.**	$0 copay for each Medicare-covered partial hospitalization day.
Personal care services (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services: Personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable members to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Prior authorization may be required.	
Personal emergency response system We cover a personal emergency response system to provide you with access to help in the event of an emergency, 24 hours a day, 7 days a week. This benefit includes the equipment (in-home or mobile with GPS), shipping, fulfillment, monitoring and customer service. You may call LifeStation at this toll free number 1-855-798-9948 to sign up.	$0 copay for the personal emergency response system.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, as long as your provider can offer these services via telehealth, including: ◦ Primary care physician services ◦ Physician specialist services ◦ Diabetes self-management training services ◦ Kidney disease education services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Occupational therapy services ◦ Opioid treatment services ◦ Outpatient substance abuse services (individual sessions) ◦ Outpatient substance abuse services (group sessions) ◦ Physical and speech therapy services ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services • This coverage is in addition to the telehealth services	$0 copay for Medicare-covered primary care physician (PCP) services (including telehealth services and urgently needed services). **Please 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. $0 copay for Medicare-covered physician specialist services (including surgery second opinion, telehealth services, home infusion professional services, and urgently needed services). $0 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including those for: • $0 copay for each primary care physician service • $0 copay for each physician specialist service • $0 copay for each diabetes self-management training service

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
described below. For more details on your additional telehealth coverage, please review your Aetna Medicare Telehealth Coverage at AetnaMedicare.com/Telehealth. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Not all providers offer telehealth services. ◦ You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, you may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc, MinuteClinic Video Visit, or other provider that offers telehealth services covered under your plan. You can access Teladoc at Teladoc.com/Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711). You can find out if MinuteClinic Video Visits are available in your area at CVS.com/MinuteClinic/virtual-care/videovisit. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services	• $0 copay for each kidney disease education service • $0 copay for each mental health service (individual sessions) • $0 copay for each mental health service (group sessions) • $0 copay for each occupational therapy service • $0 copay for each opioid treatment program service • $0 copay for each individual outpatient substance abuse service • $0 copay for each group outpatient substance abuse service • $0 copay for each physical therapy and speech therapy service • $0 copay for each psychiatric service (individual sessions) • $0 copay for each psychiatric service (group sessions) • $0 copay for each urgently needed service $0 copay for each Medicare-covered dental service.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	
Podiatry services Covered services include:	$0 copay for each Medicare-covered podiatry visit.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs In addition to Medicare-covered benefits, we also offer: • Additional non-Medicare covered podiatry services: up to twenty four visits every year	$0 copay for each non-Medicare covered podiatry visit.
Podiatry services (Medicaid) Additional coverage under the Medicaid portion of the plans benefits include medically necessary podiatry services as follows: • Up to 24 evaluation and management visits per recipient, per calendar year • Foot and nail care • Radiologic procedures specific to the foot, ankle, and lower extremity • Surgical procedures for disorders of the foot, ankle, and lower extremity **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Private duty nursing (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary private duty nursing (PDN) services provide medically necessary skilled nursing to members whose medical condition, illness, or injury requires the care to be delivered in their home or in the community. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Prostate cancer screening exams For men age 50 and older, covered services include the following – once every 12 months:	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for each Medicare-covered digital rectal exam.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Digital rectal exam • Prostate Specific Antigen (PSA) test	
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see ***"Vision care"*** later in this section for more detail. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered prosthetic device. $0 copay for Medicare-covered medical supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.**	$0 copay for each Medicare-covered pulmonary rehabilitation service.
Regional perinatal intensive care centers (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services provided at Regional Perinatal Intensive Care Center. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Reproductive services (Medicaid)	There is no coinsurance, copayment, or

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Additional coverage under the Medicaid portion of the plan's benefits include medically necessary obstetrical services, family planning services, sterilization, hysterectomy services and Therapeutic Abortion Services for terminations of pregnancies that are a result of rape or incest, or when the health of the woman is at risk. **Prior authorization may be required.**	deductible if you are eligible for full Medicaid benefits.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services provided at a county health department, Rural Health Clinic, and/or federally qualified health center (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary services. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies	$0 - 20% coinsurance for each Medicare-covered kidney disease education session. • $0 copay for QMB, QMB+, SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members $0 - 20% coinsurance for Medicare-covered outpatient dialysis, self-dialysis training, certain home support services, and home dialysis equipment and supplies. • $0 copay for QMB, QMB+,

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs." **Prior authorization may be required and is the responsibility of your provider.**	SLMB+, and FBDE members • 20% coinsurance for SLMB, QI, and QDWI members $0 per stay for each medically necessary covered inpatient stay. Cost-sharing is charged for each medically necessary covered inpatient stay. Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities, is considered a new admission. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this document. 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. Covered services include but are not limited to: • Semiprivate room (or a private room if medically	$0 per stay for each Medicare-covered SNF stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. **Prior authorization may be required and is the responsibility of your provider.** **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the**	

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
plan's benefits. Prior authorization may be required.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. In addition to Medicare-covered benefits, we also offer: • Additional individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. $0 copay for each non-Medicare covered smoking and tobacco use cessation visit.
Specialized therapeutic services (Medicaid) Additional medically necessary specialized therapeutic services may be available under the Medicaid portion of the plan's benefits including comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders. **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Speech language pathology (Medicaid) Additional speech language pathology services may be available under the Medicaid portion of the plan's benefits. Speech-language pathology services provide for the evaluation and treatment of speech language disorders to remediate and maintain communication functioning, acquire a skill set, restore a skill set, and enhance communication.	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Prior authorization may be required.	
Statewide inpatient psychiatric program (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary Statewide Inpatient Psychiatric services which provide extended residential psychiatric treatment, with the goal of facilitating successful return to treatment in a community-based setting. **Prior authorization is required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay for each Medicare-covered supervised exercise therapy service.
Transplant Services (Medicaid) Additional medically necessary transplant services may be available under the Medicaid portion of the plan's benefits including transplant services to replace bone marrow or vital	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
solid organs that are no longer functional with organs or bone marrow from a human donor. **Prior authorization may be required.**	
Transportation services (non-emergency) Coverage is provided for unlimited one-way trips every year*. Trips are provided to plan approved health-related locations via taxi, rideshare services, van. All trips are subject to a mileage limit of up to 60 miles each trip, unless pre-approved by the plan. Our plan has partnered with Access2Care to provide this benefit. **If you are eligible for full Medicaid benefits, additional services may be available under the Medicaid portion of the plan's benefits. Prior authorization may be required.** Please call Access2Care at 1-855-814-1699 at least 48 hours in advance to schedule a trip. All trips are subject to a mileage limit unless pre-approved by the plan.	$0 copay for each transportation service.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. In addition to Medicare-covered benefits, we also offer: • Urgent care (worldwide)	$0 copay for each Medicare-covered urgent care facility visit. (See ***"Physician/Practitioner services, including doctor's office visits"*** for information about urgently needed services provided in a physician's office.) $0 copay for each urgent care visit worldwide (i.e., outside the United States).
Vision care Covered services include:	$0 copay for services for the diagnosis and treatment of diseases and injuries

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

Services that are covered for you	What you must pay when you get these services
***** Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) In addition to Medicare-covered benefits, we also offer: • Non-Medicare covered eye exams (refractions): one exam every year***** • Follow-up diabetic eye exam*****	of the eye. $0 copay for each Medicare-covered glaucoma screening. $0 copay for the initial diabetic eye exam each year. $0 copay for each follow-up diabetic eye exam. $0 copay for Medicare-covered eyewear. $0 copay for each non-Medicare covered eye exam. Additional cost sharing may apply if you receive additional services during your visit.
Vision care — eyewear (non-Medicare covered) Non-Medicare covered prescription eyewear: • Contact lenses***** • Eyeglasses (lenses and frames)***** • Upgrades***** **Non-Medicare covered eyewear maximum benefit:** Plan pays up to $400 every year for non-Medicare covered prescription eyewear. You are responsible for any amount above the eyewear coverage limit. Network: iCare	Non-Medicare covered prescription eyewear: • Contact lenses: $0 copay OR • Eyeglasses (lenses and frames): $0 copay (three pairs every year) • Upgrades (UV protection and scratch coating): $0 copay

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
Our plan partners with iCare to provide your eyewear benefits. To locate a network provider, search the online provider directory at myicarehealth.com/find-a-provider or call Member Services. If you choose to use a provider outside of the network, your services will not be covered. Please note, refraction eye exams are only covered at an optometrist's office.	
Visual care (Medicaid) Additional coverage under the Medicaid portion of the plan's benefits include medically necessary vision services as follows: Eyeglasses: • Two pairs of eyeglasses every 365 days for members under the age of 21 • One pair of frames every two years, and two lens every 365 days for members over the age of 21 Contacts: • Medicaid only covers contacts when the member has a documented medical condition where eyeglasses would not provide any benefit Medicaid visual care services provide eye examinations, diagnosis, treatment, and management related to ocular and adnexal pathology. **Prior authorization may be required.**	There is no coinsurance, copayment, or deductible if you are eligible for full Medicaid benefits.
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. $0 copay for a Medicare-covered EKG following the "Welcome to Medicare" preventive visit.

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

Services that are covered for you	What you must pay when you get these services
* Services with an asterisk do not apply to your in-network out-of-pocket maximum.	
know you would like to schedule your "Welcome to Medicare" preventive visit.	
Wigs for hair loss related to chemotherapy This benefit is offered for hair loss as a result of chemotherapy. Plan pays up to $400 every year for covered wigs. You are responsible for any amount above the wig coverage limit. Members can obtain the benefit by locating a local durable medical equipment (DME) provider on AetnaMedicare.com or pay for the services up front and submit a claim for reimbursement.	$0 copay for each covered item.

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

2023 FL Liberty DSNP Den 300 Mandatory Schedule of Benefits

Our plan partners with Liberty Dental to provide your dental benefits. Please note that some services require authorization prior to treatment. These prior authorizations are clinically reviewed to determine if the requested services are necessary and appropriate based upon industry standards and Liberty clinical guidelines. If the prior authorization is denied, the service will not be covered and you will be responsible for all associated costs. To locate a network provider, you may call Member Services at (866) 610-0282 or search the Liberty Dental online provider directory at libertydentalplan.com/AetnaMedicare. If you choose to use a provider outside of the network, the services you receive will not be covered.

Maximum Benefit	**None**
Deductible	**None**

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
Diagnostic Services					
D0120	Periodic oral evaluation	$0			2 (D0120) per calendar year; not within 6 months of D0150
D0140	Limited oral evaluation	$0			2 (D0140) every calendar year
D0145	Oral evaluation under age 3	$0	0-2		2 (D0145) every calendar year
D0150	Comprehensive oral evaluation	$0			1 (D0150) every 3 calendar years; not within 3 calendar years of D0120
D0180	Comprehensive periodontal evaluation	$0			1 (D0180) every 3 calendar years
D0190	Screening of a patient	$0	0-20		1 (D0190) every 6 months
D0191	Assessment of a patient	$0	0-20		1 (D0191) every 6 months
D0210	Intraoral, complete series of radiographic images	$0			1 of (D0210, D0330) every 3 calendar years
D0220	Intraoral, periapical, first radiographic image	$0			6 of (D0220, D0230) every calendar year
D0230	Intraoral, periapical, each add'l radiographic image	$0			

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D0240	Intraoral, occlusal radiographic image	$0			2 (D0240) every calendar year
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0			1 (D0250) every calendar year
D0251	Extra-oral posterior dental radiographic image	$0			3 (D0251) every calendar year
D0270	Bitewing, single radiographic image	$0			1 of (D0270-D0274) every calendar year
D0272	Bitewings, two radiographic images	$0			
D0273	Bitewings, three radiographic images	$0			
D0274	Bitewings, four radiographic images	$0			
D0330	Panoramic radiographic image	$0			1 of (D0210, D0330) every 3 calendar years
D0340	2D cephalometric radiographic image, measurement and analysis	$0	0-20		1 (D0340) every calendar year
D0350	2D oral/facial photographic image, intra-orally/extra-orally	$0	0-20		1 (D0350) every calendar year
D0460	Pulp vitality tests	$0			3 (D0460) every 2 calendar years
Preventive Services					
D1110	Prophylaxis, adult	$0			2 of (D1110-D1120) every calendar year
D1120	Prophylaxis, child	$0	0-20		
D1206	Topical application of fluoride varnish	$0	0-20		1 of (D1206, D1208) every 6 months
D1208	Topical application of fluoride, excluding varnish	$0	0-20		
D1330	Oral hygiene instruction	$0	0-20		1 (D1330) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D1351	Sealant, per tooth	$0	0-20		1 (D1351) per tooth every calendar year
D1354	Interim caries arresting medicament application, per tooth	$0	0-20		1 (D1354) per tooth every 6 months
D1355	Caries preventive medicament application, per tooth	$0	0-20		1 (D1355) per tooth every calendar year
D1510	Space maintainer, fixed, unilateral, per quadrant	$0	0-20		3 (D1510) every calendar year
D1516	Space maintainer, fixed, bilateral, maxillary	$0	0-20		2 (D1516) every calendar year
D1517	Space maintainer, fixed, bilateral, mandibular	$0	0-20		2 (D1517) every calendar year
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$0	0-20		1 (D1551) every calendar year
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$0	0-20		3 (D1552) every calendar year
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0	0-20		2 (D1553) every calendar year
D1556	Removal of fixed unilateral space maintainer, per quadrant	$0	0-20		1 (D1556) every calendar year
D1557	Removal of fixed bilateral space maintainer, maxillary	$0	0-20		1 (D1557) every calendar year
D1558	Removal of fixed bilateral space maintainer, mandibular	$0	0-20		1 (D1558) every calendar year
D1575	Distal shoe space maintainer, fixed, per quadrant	$0	0-20		3 (D1575) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D1999	Unspecified preventive procedure, by report	$0			1 (D1999) per date of service per office, covered for Personal Protective Equipment (PPE) – VAL
Restorative Services					
D2140	Amalgam, one surface, primary or permanent	$0			4 of (D2140-D2394) every calendar year
D2150	Amalgam, two surfaces, primary or permanent	$0			
D2160	Amalgam, three surfaces, primary or permanent	$0			
D2161	Amalgam, four or more surfaces, primary or permanent	$0			
D2330	Resin-based composite, one surface, anterior	$0			
D2331	Resin-based composite, two surfaces, anterior	$0			
D2332	Resin-based composite, three surfaces, anterior	$0			
D2335	Resin-based composite, four or more surfaces, involving incisal angle	$0			
D2390	Resin-based composite crown, anterior	$0			
D2391	Resin-based composite, one surface, posterior	$0			
D2392	Resin-based composite, two surfaces, posterior	$0			
D2393	Resin-based composite, three surfaces, posterior	$0			
D2394	Resin-based composite, four or more surfaces, posterior	$0			
D2710	Crown, resin-based composite (indirect)	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D2720	Crown, resin with high noble metal	$0		Y	3 of (D2710-D2792, D6210-D6792) every calendar year; 1 per tooth every 5 calendar years
D2721	Crown, resin with predominantly base metal	$0		Y	
D2722	Crown, resin with noble metal	$0		Y	
D2740	Crown, porcelain/ceramic	$0		Y	
D2750	Crown, porcelain fused to high noble metal	$0		Y	
D2751	Crown, porcelain fused to predominantly base metal	$0		Y	
D2752	Crown, porcelain fused to noble metal	$0		Y	
D2753	Crown, porcelain fused to titanium and titanium alloys	$0		Y	
D2780	Crown, ¾ cast high noble metal	$0		Y	
D2781	Crown, ¾ cast predominantly base metal	$0		Y	
D2782	Crown, ¾ cast noble metal	$0		Y	
D2783	Crown, ¾ porcelain/ceramic	$0		Y	
D2790	Crown, full cast high noble metal	$0		Y	
D2791	Crown, full cast predominantly base metal	$0		Y	
D2792	Crown, full cast noble metal	$0		Y	
D2920	Re-cement or re-bond crown	$0			
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	$0			1 (D2928) every calendar year
D2930	Prefabricated stainless steel crown, primary tooth	$0	0-20		1 (D2930) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D2931	Prefabricated stainless steel crown, permanent tooth	$0	0-20		1 (D2931) every calendar year
D2932	Prefabricated resin crown	$0	0-20		1 (D2932) every calendar year
D2933	Prefabricated stainless steel crown with resin window	$0	0-20		1 (D2933) every calendar year
D2940	Protective restoration	$0	0-20		1 (D2940) every calendar year
D2950	Core buildup, including any pins when required	$0			3 of (D2950-D2954) every calendar year; 1 per tooth every 5 calendar years
D2951	Pin retention, per tooth, in addition to restoration	$0			
D2952	Post and core in addition to crown, indirectly fabricated	$0			
D2953	Each additional indirectly fabricated post, same tooth	$0			
D2954	Prefabricated post and core in addition to crown	$0			
Endodontic Services					
D3110	Pulp cap, direct (excluding final restoration)	$0	0-20		1 (D3110) per tooth every calendar year
D3120	Pulp cap, indirect (excluding final restoration)	$0	0-20		
D3220	Therapeutic pulpotomy (excluding final restoration)	$0	0-20		
D3221	Pulpal debridement, primary and permanent teeth	$0	0-20		
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$0	0-20		
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$0	0-20		

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	$0	0-20		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$0		Y	2 (D3310-D3330) every calendar year; 1 per tooth in a lifetime
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$0		Y	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$0		Y	
D3331	Treatment of root canal obstruction; non-surgical access	$0	0-20		1 (D3331) per tooth every calendar year
D3333	Internal root repair of perforation defects	$0	0-20		1 (D3333) per tooth every calendar year
D3346	Retreatment of previous root canal therapy, anterior	$0		Y	2 (D3346-D3348) every calendar year; 1 per tooth in a lifetime
D3347	Retreatment of previous root canal therapy, premolar	$0		Y	
D3348	Retreatment of previous root canal therapy, molar	$0		Y	
D3351	Apexification/recalcification, initial visit	$0	0-20	Y	1 (D3351) per tooth every calendar year
D3352	Apexification/recalcification, interim medication replacement	$0	0-20	Y	1 (D3352) per tooth every calendar year
D3353	Apexification/recalcification, final visit	$0	0-20	Y	1 (D3353) per tooth every calendar year
D3410	Apicoectomy, anterior	$0	0-20	Y	1 (D3410) per tooth every calendar year
D3430	Retrograde filling, per root	$0	0-20		1 (D3430) per tooth every calendar year
Periodontal Services					

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$0		Y	1 of (D4210, D4211) per quad every 2 calendar years
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$0		Y	
D4240	Gingival flap procedure, four or more teeth per quadrant	$0	0-20	Y	1 of (D4240, D4241) per quad every calendar year
D4241	Gingival flap procedure, one to three teeth per quadrant	$0	0-20	Y	
D4260	Osseous surgery, four or more teeth per quadrant	$0		Y	1 of (D4260, D4261) per quad every 2 calendar years
D4261	Osseous surgery, one to three teeth per quadrant	$0		Y	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$0			1 of (D4341, D4342) per quad every 2 calendar years
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$0			
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$0	0-20		1 (D4346) every calendar year
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, subsequent visit	$0			1 (D4355) in a lifetime
D4910	Periodontal maintenance	$0			2 (D4910) every calendar year
D4921	Gingival irrigation, per quadrant	$0			2 (D4921) per quad every 2 calendar years
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	$0		Y	1 of (D5110-D5226, D6110-D6117) per arch every 5 calendar years
D5120	Complete denture, mandibular	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D5130	Immediate denture, maxillary	$0		Y	
D5140	Immediate denture, mandibular	$0		Y	
D5211	Maxillary partial denture, resin base	$0		Y	
D5212	Mandibular partial denture, resin base	$0		Y	
D5213	Maxillary partial denture, cast metal, resin base	$0		Y	
D5214	Mandibular partial denture, cast metal, resin base	$0		Y	
D5225	Maxillary partial denture, flexible base	$0		Y	
D5226	Mandibular partial denture, flexible base	$0		Y	
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	$0		Y	1 of (D5284, D5286) per quad every 5 calendar years
D5286	Removable unilateral partial denture, one piece resin, per quadrant	$0		Y	
D5410	Adjust complete denture, maxillary	$0			1 of (D5410-D5422) per arch every calendar year
D5411	Adjust complete denture, mandibular	$0			
D5421	Adjust partial denture, maxillary	$0			
D5422	Adjust partial denture, mandibular	$0			
D5511	Repair broken complete denture base, mandibular	$0			2 of (D5511, D5512) every calendar year
D5512	Repair broken complete denture base, maxillary	$0			

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D5520	Replace missing or broken teeth, complete denture	$0			
D5611	Repair resin partial denture base, mandibular	$0			1 of (D5611, D5612) per arch every calendar year
D5612	Repair resin partial denture base, maxillary	$0			
D5621	Repair cast partial framework, mandibular	$0			1 of (D5621, D5622) per arch every calendar year
D5622	Repair cast partial framework, maxillary	$0			
D5630	Repair or replace broken retentive clasping materials, per tooth	$0			
D5640	Replace broken teeth, per tooth	$0			
D5650	Add tooth to existing partial denture	$0			1 (D5650) every calendar year
D5660	Add clasp to existing partial denture, per tooth	$0			1 (D5660) every calendar year
D5730	Reline complete maxillary denture, direct	$0			1 of (D5730-D5761) per arch every 2 calendar years
D5731	Reline complete mandibular denture, direct	$0			
D5740	Reline maxillary partial denture, direct	$0			
D5741	Reline mandibular partial denture, direct	$0			
D5750	Reline complete maxillary denture, indirect	$0			
D5751	Reline complete mandibular denture, indirect	$0			
D5760	Reline maxillary partial denture, indirect	$0			
D5761	Reline mandibular partial denture, indirect	$0			

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D5810	Interim complete denture, maxillary	$0	0-20	Y	1 of (D5810-D5821) per arch every 5 calendar years
D5811	Interim complete denture, mandibular	$0	0-20	Y	
D5820	Interim partial denture, maxillary	$0	0-20	Y	
D5821	Interim partial denture, mandibular	$0	0-20	Y	
Implant Services					
D6010	Surgical placement of implant body, endosteal	$0		Y	2 of (D6010, D6013) every calendar year; 1 per tooth every 5 calendar years
D6013	Surgical placement of mini implant	$0		Y	
D6055	Connecting bar, implant supported or abutment supported	$0		Y	1 (D6055) every calendar year
D6056	Prefabricated abutment, includes modification and placement	$0		Y	2 of (D6056, D6057) every calendar year; 1 per tooth every 5 calendar years
D6057	Custom fabricated abutment, includes placement	$0		Y	
D6058	Abutment supported porcelain/ceramic crown	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6060	Abutment supported porcelain fused to base metal crown	$0		Y	
D6061	Abutment supported porcelain fused to noble metal crown	$0		Y	
D6063	Abutment supported cast metal crown, base metal	$0		Y	
D6064	Abutment supported cast metal crown, noble metal	$0		Y	
D6065	Implant supported porcelain/ceramic crown	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D6068	Abutment supported retainer, porcelain/ceramic FPD	$0		Y	
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$0		Y	
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$0		Y	
D6073	Abutment supported retainer, cast metal FPD, base metal	$0		Y	
D6074	Abutment supported retainer, cast metal FPD, noble	$0		Y	
D6075	Implant supported retainer for ceramic FPD	$0		Y	
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$0			2 (D6080) every calendar year
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	$0			1 (D6081) per tooth every 2 calendar years
D6082	Implant supported crown, porcelain fused to predominantly base alloys	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6083	Implant supported crown, porcelain fused to noble alloys	$0		Y	
D6086	Implant supported crown, predominantly base alloys	$0		Y	
D6087	Implant supported crown, noble alloys	$0		Y	
D6088	Implant supported crown, titanium and titanium alloys	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D6090	Repair implant supported prosthesis, by report	$0			1 (D6090) per site every calendar year
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$0			1 (D6091) every calendar year
D6092	Re-cement or re-bond implant/abutment supported crown	$0			1 (D6092) per site every calendar year
D6093	Re-cement or re-bond implant/abutment supported FPD	$0			1 (D6093) per site every calendar year
D6095	Repair implant abutment, by report	$0			1 (D6095) per site every calendar year
D6096	Remove broken implant retaining screw	$0			1 (D6096) every calendar year
D6097	Abutment supported crown, porcelain fused to titanium and titanium alloys	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$0		Y	
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$0		Y	
D6100	Implant removal, by report	$0			1 (D6100) per tooth in a lifetime
D6101	Debridement of a peri-implant defect(s), surrounding single implant, including flap entry/closure	$0			1 (D6101) per tooth every 2 calendar years
D6102	Debridement and osseous contouring of a peri-implant defect(s) surrounding single implant, including flap entry/closure	$0			1 (D6102) per tooth every 2 calendar years

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D6104	Bone graft at time of implant placement	$0		Y	2 (D6104) every calendar year
D6110	Implant/abutment supported removable denture, maxillary	$0		Y	1 of (D5110-D5226, D6110-D6117) per arch every 5 calendar years
D6111	Implant/abutment supported removable denture, mandibular	$0		Y	
D6112	Implant/abutment supported removable denture, partial, maxillary	$0		Y	
D6113	Implant/abutment supported removable denture, partial, mandibular	$0		Y	
D6114	Implant/abutment supported fixed denture, maxillary	$0		Y	
D6115	Implant/abutment supported fixed denture, mandibular	$0		Y	
D6116	Implant/abutment supported fixed denture for partial, maxillary	$0		Y	
D6117	Implant/abutment supported fixed denture for partial, mandibular	$0		Y	
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$0		Y	2 of (D6058-D6075, D6082-D6088, D6097-D6099, D6121-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
D6122	Implant supported retainer for metal FPD, noble alloys	$0		Y	
D6123	Implant supported retainer for metal FPD, titanium and titanium alloys	$0		Y	
D6191	Semi-precision abutment, placement	$0		Y	2 (D6191) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D6194	Abutment supported retainer crown for FPD titanium, titanium and titanium alloys	$0		Y	2 of (D6058-D6123, D6194) every calendar year; 1 per tooth every 5 calendar years
Fixed Prosthodontic Services					
D6210	Pontic, cast high noble metal	$0		Y	3 of (D2710-D2792, D6210-D6792) every calendar year; 1 per tooth every 5 calendar years
D6211	Pontic, cast predominantly base metal	$0			
D6212	Pontic, cast noble metal	$0			
D6214	Pontic, titanium, and titanium alloys	$0			
D6240	Pontic, porcelain fused to high noble metal	$0			
D6241	Pontic, porcelain fused to predominantly base metal	$0			
D6242	Pontic, porcelain fused to noble metal	$0			
D6243	Pontic, porcelain fused to titanium and titanium alloys	$0			
D6245	Pontic, porcelain/ceramic	$0			
D6250	Pontic, resin with high noble metal	$0			
D6251	Pontic, resin with predominantly base metal	$0			
D6252	Pontic, resin with noble metal	$0			
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$0			
D6720	Retainer crown, resin with high noble metal	$0			
D6721	Retainer crown, resin with predominantly base metal	$0			
D6722	Retainer crown, resin with noble metal	$0			

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D6740	Retainer crown, porcelain/ceramic	$0			
D6750	Retainer crown, porcelain fused to high noble metal	$0			
D6751	Retainer crown, porcelain fused to predominantly base metal	$0			
D6752	Retainer crown, porcelain fused to noble metal	$0			
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	$0			
D6780	Retainer crown, ¾ cast high noble metal	$0			
D6781	Retainer crown, ¾ cast predominantly base metal	$0			
D6782	Retainer crown, ¾ cast noble metal	$0			
D6783	Retainer crown, ¾ porcelain/ceramic	$0			
D6784	Retainer crown ¾, titanium and titanium alloys	$0			
D6790	Retainer crown, full cast high noble metal	$0			
D6791	Retainer crown, full cast predominantly base metal	$0			
D6792	Retainer crown, full cast noble metal	$0			
D6985	Pediatric partial denture, fixed	$0	0-20	Y	1 (D6985) every calendar year
Oral & Maxillofacial Services					
D7111	Extraction, coronal remnants, primary tooth	$0			1 (D7111) per tooth in a lifetime
D7140	Extraction, erupted tooth or exposed root	$0			8 of (D7140-D7241) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$0		Y	
D7220	Removal of impacted tooth, soft tissue	$0		Y	
D7230	Removal of impacted tooth, partially bony	$0		Y	
D7240	Removal of impacted tooth, completely bony	$0		Y	
D7241	Removal impacted tooth, complete bony, complication	$0		Y	
D7250	Removal of residual tooth roots (cutting procedure)	$0		Y	1 (D7250) per tooth in a lifetime
D7260	Oroantral fistula closure	$0		Y	1 (D7260) every calendar year
D7261	Primary closure of a sinus perforation	$0		Y	1 (D7261) every calendar year
D7270	Tooth reimplantation and/or stabilization, accident	$0	0-20	Y	1 (D7270) every calendar year
D7280	Exposure of an unerupted tooth	$0	0-20		1 (D7280) every calendar year
D7283	Placement, device to facilitate eruption, impaction	$0	0-20	Y	1 (D7283) every calendar year
D7296	Corticotomy, one to three teeth or tooth spaces, per quadrant	$0	0-20	Y	1 of (D7296, D7297) per quad every calendar year
D7297	Corticotomy, four or more teeth or tooth spaces, per quadrant	$0	0-20	Y	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$0		Y	1 of (D7310-D7321) per quad every calendar year
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$0		Y	

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$0		Y	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$0		Y	
D7472	Removal of torus palatinus	$0		Y	1 (D7472) every calendar year
D7473	Removal of torus mandibularis	$0		Y	1 (D7473) every calendar year
D7510	Incision & drainage of abscess, intraoral soft tissue	$0			1 (D7510) every calendar year
D7520	Incision & drainage of abscess, extraoral soft tissue	$0			1 (D7520) every calendar year
D7880	Occlusal orthotic device, by report	$0	0-20	Y	1 (D7880) every calendar year
D7881	Occlusal orthotic device adjustment	$0	0-20	Y	1 (D7881) every calendar year
D7970	Excision of hyperplastic tissue, per arch	$0			1 (D7970) per arch every calendar year
Orthodontic Services					
D8070	Comprehensive orthodontic treatment of the transitional dentition	$0	0-20	Y	1 of (D8070-D8090) in a lifetime
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$0	0-20	Y	
D8090	Comprehensive orthodontic treatment of the adult dentition	$0	0-20	Y	
D8210	Removable appliance therapy	$0	0-20	Y	1 (D8210) in a lifetime
D8220	Fixed appliance therapy	$0	0-20	Y	1 (D8220) in a lifetime
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0	0-20	Y	1 (D8660) every calendar year

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D8670	Periodic orthodontic treatment visit	$0	0-20	Y	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$0	0-20	Y	1 (D8680) per arch every calendar year
D8703	Replacement of lost or broken retainer, maxillary	$0	0-20	Y	1 (D8703) in a lifetime
D8704	Replacement of lost or broken retainer, mandibular	$0	0-20	Y	1 (D8704) in a lifetime
Adjunctive General Services					
D9110	Palliative (emergency) treatment, minor procedure	$0	0-20		
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0			
D9222	Deep sedation/general anesthesia, first 15 minute increment	$0		Y	7 of (D9222, D9223) per date of service
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$0		Y	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$0			
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$0		Y	7 of (D9239, D9243) per date of service
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$0		Y	
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$0			

CPT Code	Description	Member Responsibility	Age Limits	Approved Pre-Auth Required	Limitations
D9310	Consultation, other than requesting dentist	$0	0-20		1 (D9310) every calendar year
D9920	Behavior management, by report	$0	0-20		
D9944	Occlusal guard, hard appliance, full arch	$0		Y	1 (D9944-D9946) per arch every 5 calendar years
D9945	Occlusal guard, soft appliance, full arch	$0		Y	
D9946	Occlusal guard, hard appliance, partial arch	$0		Y	
D9995	Teledentistry, synchronous; real-time encounter	$0			
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	$0			

LIMITATIONS AND EXCLUSIONS

1. Services which, in the opinion of the network general dentist or specialist, are not necessary for the patient's dental health.
2. Cosmetic or experimental dental services, and/or procedures not generally performed in a general dentist office.
3. Cost of hospitalization and/or pharmaceuticals.
4. Any services performed by a non-network general dentist or non-network specialist.
5. Services that cannot be performed because of the general health of the patient.
6. Services which are not consistent with the usual and customary services provided by a network general dentist or specialist.
7. Any dental treatment started prior to the member's effective date.
8. Treatment related to cysts, neoplasms and/or malignancies.
9. Any procedure not specifically listed as a covered benefit in this Schedule of Benefits.
10. Fees related to broken appointments, preparing or copying dental reports, duplication of x rays, itemized bills or claim forms are not covered.
11. Services for injuries and/or conditions which are paid or payable under Worker's Compensation or Employer Liability Laws, and treatment provided without cost to you by any municipality, county, or other political subdivision is not covered.
12. 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.

13. 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.
14. Implant services are only covered by the Plan under certain circumstances in accordance with Liberty's clinical criteria. For example, implants for posterior teeth would only be covered when there are enough teeth remaining and a denture or partial denture is not more appropriate. Prior authorization is required.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services *not* covered by the plan

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

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 receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not 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 have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances. Our plan provides some additional coverage for acupuncture as described in the *Medical Benefits Chart.*

Services not covered by Medicare	Not covered under any condition	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 does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		Custodial care may be available under the Medicaid portion of the plan's benefits. Members must meet specific criteria and custodial care services must be prior authorized. Please see the *Medical Benefits Chart* for more information.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by 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. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		Our plan provides some coverage for home-delivered meals as described in the *Medical Benefits Chart*.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments)	✓	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
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.	✓	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered. Our plan provides some additional coverage for routine chiropractic care as described in the *Medical Benefits Chart*. Additional services may be available under the Medicaid portion of the plan's benefits. Please see the *Medical Benefits Chart* for more information.

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

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

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

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

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. Please contact Member Services for information about drugs covered under your Medicaid coverage.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?
To find a network pharmacy, you can look in your *Provider & Pharmacy Directory*, visit our website (AetnaMedicare.com/findpharmacy), or call Member Services.

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

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

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

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

To locate a specialized pharmacy, look in your *Provider & Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order service

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

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

To get order forms and information about filling your prescriptions by mail, visit our website (AetnaMedicare.com) or contact Member Services. Note: you must have a method of payment on file.

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

medications, you may request this from the Member Services representative for an additional charge.

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

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by continuing to have your doctor send us your prescriptions. No special request is needed. Or you may contact Member Services to restart automatic deliveries if you previously stopped automatic deliveries.

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

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

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

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

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

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

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

The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List (For tiers 1-4). (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider & Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3

for more information.

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

Your prescription may be covered in certain situations
Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

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

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

How do you ask for reimbursement from the plan?
If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

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

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

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

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

What is *not* on the Drug List?
The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

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

You have three ways to find out:

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

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the

most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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

Restricting brand name drugs when a generic version is available
Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you *OR* has written "No substitutions" on your prescription for a brand name drug *OR* has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

Getting plan approval in advance
For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called ***"prior authorization."*** This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

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

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

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

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

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

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

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

If your drug is not on the Drug List or is restricted, here are options:

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

You may be able to get a temporary supply
Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

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

For questions about a temporary supply, call Member Services.

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

1) You can change to another drug
Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

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

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

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

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

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

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

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

Information on changes to drug coverage
When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking.

Changes to your drug coverage that affect you during the current plan year

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

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

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

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

probably won't see any increase in your payments or any added restrictions to your use of the drug.

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

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

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself, except for certain excluded drugs covered under our enhanced drug coverage.

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

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

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Please contact the state Medicaid agency listed in **Addendum A** at the back of this document for information about drugs covered under your Medicaid coverage. (Our plan covers certain drugs listed below through our enhanced drug coverage. More information is provided below.)

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

We cover some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). These covered excluded drugs include select generic prescription vitamins, minerals, and erectile dysfunction medicine. These drugs and their prior authorization requirements and quantity limits

are listed at the end of the Drug List (formulary) booklet. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.

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

SECTION 8 Filling a prescription

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you**. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

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

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

Check your *Provider & Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D

benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?
Please refer to Section 5.2 about a temporary or emergency supply.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

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

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we

may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

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

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

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

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

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

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

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about theses programs, please contact Member Services.

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

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

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

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

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *Part D Explanation of Benefits* ("Part D EOB"). The Part D EOB includes:

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances

  If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Be sure to keep these reports.

Chapter 6:
What you pay for your Part D prescription drugs

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

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

Chapter 7:

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

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

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

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will 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.

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

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network
You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

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

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. We do

not allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for the difference between the amount you paid and the amount you owed under the plan.

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

6. When you pay the full cost for a prescription in other situations
You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

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

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision.
Chapter 9 of this document has information about how to make an appeal.

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

You may request us to pay you back by either calling us or 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.

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

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

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

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

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

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

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

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

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

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

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement for our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

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

Chapter 8:
Your rights and responsibilities

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

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, in braille, in large print, or other alternate formats, etc.)

Your 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 a plan may meet these accessibility requirements include, but are not 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. Many documents are also available in Spanish. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

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

Su 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. Algunos ejemplos de cómo un plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono para mensajes o teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder las preguntas de los miembros que no hablan inglés. Muchos documentos también están disponibles en español. También

podemos proporcionarle información en braille, en tamaño de letra grande o en otros formatos alternativos, sin costo alguno, si lo necesita. Debemos proporcionarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información sobre nosotros de una manera que sea conveniente para usted, llame al Departamento de Servicios para Miembros.

Nuestro plan está obligado a ofrecer a las mujeres inscritas la opción de acceder directamente a un especialista en salud de la mujer dentro de la red para los servicios de atención médica de rutina y preventivos para la mujer.

Si no están disponibles los proveedores de la red del plan para una especialidad, es responsabilidad del plan localizar proveedores especializados fuera de la red que le proporcionen la atención necesaria. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialidades en la red del plan que cubran un servicio que necesita, llame al plan para que le informen dónde acudir para obtener ese servicio con un costo compartido dentro de la red.

Si tiene alguna dificultad para obtener información sobre nuestro plan en un formato que sea accesible y adecuado para usted, llámenos para presentar una queja ante el Departamento de Servicios para Miembros (los números de teléfono están impresos en la contraportada de este documento). También puede presentar un reclamo ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles llamando al 1-800-368-1019 o al TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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 are 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 do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

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

As a member of Aetna Medicare Assure Plus (HMO D-SNP), you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and network pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapter 5 provides information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.
- **Information from interpreters.** Our plan interpreter services are available in all languages including

American Sign Language. Interpreter services are available for on-site interpretation during a medical appointment. If you require these services, please contact Member Services at least two weeks in advance of your scheduled appointment.

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

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

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself
Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to,* you can:

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

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that

give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form 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 are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

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

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

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your SHIP. Contact information is in **Addendum A** at the back of this document.

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

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

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights
If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?
If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the State Health Insurance Assistance Program (SHIP)**. For details, go to Chapter 2, Section 3 or **Addendum A** at the back of this document.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
- You can **call Medicaid**. For details refer to **Addendum A** of this document for the name and contact information for the Medicaid program in your state.
- You can **call your Ombudsman**. For details refer to **Addendum A** of this document for the name and contact information for the Ombudsman programs in your state.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the State Health Insurance Assistance Program (SHIP).** For details, go to Chapter 2, Section 3 or **Addendum A** at the back of this document.
- You can contact **Medicare.**
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **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 is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapter 5 gives the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay your Medicare premiums to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our 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* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 9:

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

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Member Services.
2. The type of problem you are having:
   - For some types of problems, you need to use the **process for coverage decisions and appeals**.
   - For other types of problems, you need to use the **process for making complaints;** also called grievances.

These 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the 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 and can be hard to understand. To keep things simple, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” or “at-risk determination,” and “independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Member Services for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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 are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in **Addendum A**.

Medicare
You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

You can get help and information from Medicaid
Contact information for your state's Medicaid agency can be found in **Addendum A**.

SECTION 3 To deal with your problem, which process should you use?

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Member Services.

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Medicaid benefits?
If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Member Services.

My problem is about **Medicare** benefits.

> Go to the next section of this chapter, **Section 4, "Handling problems about your Medicare benefits."**

My problem is about **Medicaid** coverage.

> Skip ahead to **Section 12** of this chapter, ***"Handling problems about your Medicaid benefits."***

PROBLEMS ABOUT YOUR MEDICARE BENEFITS

SECTION 4 Handling problems about your Medicare benefits

Section 4.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

Is your problem or concern about your benefits or coverage?
This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 5, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 11** at the end of this chapter: ***"How to make a complaint about quality of care, waiting times, customer service or other concerns."***

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1	Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your

behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal
If we make a coverage decision and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request 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 were properly following all of the rules. When we have completed the review, we give you our decision.

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.)

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.2 How to get help when you are 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:

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.
  - For medical care, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or other prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for

you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 8** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 9** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different

from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 6.2**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 6.2**.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

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, you need to read Sections 7 and 8 of this chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it 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 14 days 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. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a *"fast coverage decision,"* we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your doctor asks for a coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested

Step 2: Ask our plan to make a coverage decision or a 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 will give you an answer within 14 calendar days after we receive your request for a **medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." We will give you an answer to your complaint as soon as we make a decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days.** If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

Step 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 are going on to Level 1 of the appeals process.

Section 6.3	Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the 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 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will 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 6.2 of this chapter.

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

- **If you are asking for a standard appeal, submit your standard appeal in writing**. Chapter 2 has contact information.
- **If you are 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 60 calendar days** from the date on the written notice we sent to tell you our answer to your request on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information 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 we are reviewing your appeal, we take another careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - 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 will tell you in writing. We can't take extra time if your request is for a

Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard" appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need 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 will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should **not** take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 11 of this chapter for information on complaints.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 6.4	Step-by-step: How a Level 2 appeal is done

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

The **independent review organization is an independent organization hired by Medicare**. It is not

connected with us and is not a government agency. The 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 will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date the plan receives the independent review organization's decision for **expedited requests.**
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug under dispute **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests.**

- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
  - Explaining its decision
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage you are requesting 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.
  - Telling 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 three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter explains the Levels 3, 4, and 5 appeals processes.

Section 6.5	What if you are asking us to pay you back for our share of a bill you have received for medical care?

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

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

- **If we say yes to your request:** If the medical care you paid for is covered and you followed all the rules, we will send you the payment forour share of the cost the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will 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 will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

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

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not 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 requested to you or to the provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapter 5. **This section is about your Part D drugs only**. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or "Formulary."

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

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for**

an exception. Section 7.2
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

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

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

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

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

1. **Covering a Part D drug for you that is not on our Drug List.** You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction on our coverage for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your

condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 Specialty.
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons
Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for a review of our decision by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A "fast coverage decision" is called an ***"expedited coverage determination."***

<u>Step 1</u>: Decide if you need a *"standard coverage decision"* or a *"fast coverage decision."*

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

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

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision

to be paid back for a drug you have already bought.)
- Using the standard deadlines *could cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decisions."

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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

- **If you are requesting an exception, provide the "supporting statement,"** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a "fast coverage decision"

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

Deadlines for a "standard" coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request**.**
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

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

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

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

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan ***"redetermination."*** A "fast appeal" is also called an ***"expedited redetermination."***

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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your

doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 1-833-570-6670. Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add additional information to support your appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

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

Deadlines for a "standard" appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and

your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal. **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

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

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

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

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

Section 7.6 Step-by-step: How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program,

we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal

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

Deadlines for "fast" appeal

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

Deadlines for "standard" appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

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

For "fast appeals":

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

For "standard appeals":

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

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to

approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to 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 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

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

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will 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 two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**.
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

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

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you

how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

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 may 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 do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4 of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will 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 is 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 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Step 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 may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will 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 is 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 review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

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

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

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

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their 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 that your coverage for the care ended.

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

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

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

If the review organization says yes:

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

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If 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 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 appeal?

Legal Term
A *"fast" review* (or "fast appeal") is also called an ***"expedited appeal."***

You can appeal to us instead
As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, the *first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Step 1: Contact us and ask for a *"fast review."*

- **Ask for a *"fast review."*** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a *"fast" review* of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a "fast review."

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

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

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a *"fast review"* of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree that your planned hospital

discharge date was medically appropriate.
- The written notice you get from the independent review organization will tell how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1	*This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

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

Section 9.2	We will tell you in advance when your coverage will be ending

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

1. You receive a notice in writing at least two days before our plan is going to stop covering your care. This notice tells you:

- The date when we will stop covering the care for you.
- How to request a "fast track appeal" to request us 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 received it. Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does *not* mean you agree** with the plan's decision to stop care.

Section 9.3	Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process**.
- **Meet the deadlines**.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

How can you contact this organization?

- The written notice you received (*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 Chapter 2.)

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.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5 of this chapter.

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

Legal Term
"Detailed Explanation of Non-Coverage." Notice that provides 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 may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will 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 is medically necessary.**
- You will 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 have 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 will have to pay the full cost** of this care yourself.

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

- 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 9.4	Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead
As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Term
A "fast review" (or "fast appeal") is also called an ***"expedited appeal."***

Step 1: Contact us and ask for a *"fast review."*

- **As for a *"fast review."*** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a *"fast review"* of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a *"fast review."*

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: Level 2 *Alternate* appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision we made should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work .

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a *"fast review"* of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**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 Level 2 appeal we have the right to appeal a Level 3 decision that is 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 service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. 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 will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you 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 on 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 of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both

of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 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 the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (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 are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

- A ***"Complaint"*** is also called a ***"grievance."***
- ***"Making a complaint"*** is also called ***"filing a grievance."***
- ***"Using the process for complaints"*** is also called ***"using the process for filing a grievance."***
- A ***"fast complaint"*** is also called an ***"expedited grievance."***

Section 11.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- To use our grievance (complaint) process, you should call or send us your written complaint using one of the contact methods listed in Chapter 2: *Important Phone Numbers and Resources (How to contact us when you are making a complaint about your Part D prescription drugs* or *medical care).*
  - Please be sure you provide all pertinent information, including any supporting documents you believe are appropriate. Your complaint must be received by us within 60 calendar days of the event or incident that resulted in you filing your complaint.

    - Your issue will be investigated by a member of our complaint team. If you submit your complaint verbally, we will inform you of the result of our review and our decision verbally or in writing. If you submit a verbal complaint and request your response to be in writing, we will respond in writing. If you send us a written complaint, we will send you a written response, stating the result of our review. Our notice will include a description of our understanding of your complaint and our decision in clear terms.
    - We must address your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if we justify a need for additional information and the delay is in your best interest.
    - You also have the right to ask for a fast "expedited" grievance. A fast "expedited" grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a fast "expedited" grievance if you disagree with:
        - Our plan to take a 14-calendar-day extension on an organization/coverage determination or reconsideration/redetermination (appeal); or
        - Our denial of your request to expedite an organization determination or reconsideration (appeal) for health services; or
        - Our denial of your request to expedite a coverage determination or redetermination (appeal) for a prescription drug.
- The fast "expedited" grievance process is as follows:
    - You or an authorized representative can call, fax, or mail your complaint and mention that you want the fast complaint or expedited grievance process. Call the phone number, fax, or write your complaint and send it to the address listed in Chapter 2*: Important Phone Numbers and Resources (How to contact us when you're making a complaint about your Part D prescription drugs)* or *(How to contact us when you are making a complaint about your medical care)*. The fastest way to submit a fast complaint is to call or fax us. The fastest way to file a grievance is to call us. When we receive your complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-calendar-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will investigate your complaint and notify you of our decision within 24 hours.
- The **deadline** for making a complaint is 60 calendar days from the time had the problem you want to complain about.

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

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

Section 11.4	You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 11.5	You can also tell Medicare about your complaint

You can submit a complaint about Aetna Medicare Assure Plus (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12 Handling problems about your Medicaid benefits

Keep in mind that most of your benefits should be covered under your Medicare benefit plan. If there are benefits that are not covered under your Medicare benefit plan, you will still have access to those benefits through your Medicaid coverage with Aetna. Aetna has a contract with the State of Florida to cover most of your Medicaid benefits as well as your Medicare benefits.
If you have a problem or concern about your covered Medicaid benefits, you can contact Aetna.
When any of your Medicaid services are denied, the appeal process is different than the one used for Medicare-based services.
For Medicaid only services, we have to follow the Medicaid process for complaints, appeals and grievances. We want you to let us know right away if you have any questions, complaints or problems with your Medicaid covered services or the care you receive. In this section we will explain how you can contact us with your concerns.

If you have a problem with your Medicaid covered services, you can file a complaint, a grievance or request an appeal.

Complaints

State law allows you to make a complaint if you have any problems with us or the services you are receiving. The state has also set the rules for making a complaint. We have to follow the state rules on handling your complaint. We have to treat you fairly and cannot disenroll you from our plan or treat you differently.

A complaint is when you are unhappy with something with our plan. (It's less formal than a grievance.) When you have a complaint, you may call or write to us. Call Member Services at 1-866-409-1221 Monday – Friday, 8 AM to 8 PM.
Or write to:

Aetna Medicare Grievances
PO Box 14834
Lexington, KY 40512

We will resolve your complaint by the close of business the next business day or change it to a formal grievance.

Grievances

A grievance is when you make a complaint about us. It can also be about a provider and/or a service. These complaints may be about:

- Quality-of-care issues
- Wait times during provider visits
- The way your providers or others act or treat you
- Unclean provider offices
- Not getting the information you need

You can file a grievance by calling, faxing or writing to us. You can call Member Services at 1-866-409-1221 Monday–Friday, 8 AM to 8 PM, or you can write to us at the following address:

Aetna Medicare Grievances
PO Box 14834
Lexington, KY 40512

You can fax us at 1-724-741-4956.

You can file your grievance yourself. Or you can have someone file it for you. (This includes your PCP or another provider.) If at any time you need help filing one, call us.

If you wish to have someone act for you, you must send us a signed statement. (It should be signed by you.) The statement must say you are allowing this person to represent you. To help you with this, we have an Appointment of Representative form on our website at AetnaMedicare.com. You can use this form to allow someone to act for you.

You can file your grievance at any time.

Within (5) five business days of receiving your grievance, we will mail you a letter letting you know that we received your grievance. We will send you another letter with our decision about your grievance no later than (90) ninety calendar days after we received the grievance.

You also have the right to request a 14-day extension if you have additional information to support your grievance. If it is in your best interest, the plan also has the right to extend the review of your grievance. If we extend the time we need to review your grievance, we will call you to let you know that additional time is needed. We will also send you a letter that tells you why we need the additional time within two calendar

days of the decision to extend our review.

Medicaid Only Benefit Appeals Process

Standard Appeals

If the plan denies your request for a service that is a Medicaid-only benefit, you, or a provider acting on your behalf with your permission, can request an appeal.

An appeal is a request you can make when you don't agree with a decision we made about your care. Or it can be for if we take too long to make a care decision. You can ask for an appeal if we:

- Deny or limit a service you or your doctor asks us to approve
- Reduce, suspend or stop services you've been getting that we already approved
- Do not pay for the health care services you get
- Fail to give services in the required time frame
- Fail to give you a decision on an appeal you already filed in the required time frame
- Don't agree to let you see a doctor who is not in our network and you live in a rural area or in an area with limited doctors

You will get a letter from us when any of these actions occur. It's called a Notice of Adverse Benefit Determination or NABD. You can file an appeal if you do not agree with our decision.

You may file your appeal by calling or writing to us within 60 calendar days from the date on the Notice of Adverse Benefit Determination. To file the appeal by calling us, call 866-241-0365 Monday – Friday, 8:00 am – 8:00 pm. If you call in your appeal, you must follow up with a written, signed appeal letter within 10 calendar days of calling in your appeal.

Send your written appeals here:

For appeal requests for pharmacy medications:

Aetna Medicare Part D Appeals
PO Box 14579
Lexington, KY 40512

You can fax your appeal to: 1-724-741-4954

For appeal requests for medical items or services and Medicare Part B prescription drugs:

Aetna Medicare Part C Appeals
PO Box 14067
Lexington, KY 40512

You can fax your appeal to: 1-724-741-4953

You can file your appeal yourself. Or you can have someone file it for you. (This includes your PCP or another provider.) We must have your written permission before someone can file an appeal for you. To have your provider appeal on your behalf, you must appoint the provider as your representative. If you

need help filing your appeal, you can always call 866-241-0365, Monday – Friday 8:00 am – 8:00 pm.

We will send you a letter within five business days of getting your appeal to let you know that we received it. We will then review the appeal and send you a Notice of Plan Appeal Resolution (NPAR) letter within 30 calendar days. The Notice of Plan Appeal Resolution letter will explain the information we reviewed and the decision we made about your appeal request.

Fast or Expedited Appeals

There may be times when you or your provider will want us to make a faster appeal decision. This could be because you or your provider feels that waiting 30 calendar days could seriously harm your health. If so, you can ask for a fast or expedited appeal.

To request a fast appeal, you or your provider can call 866-241-0365 for a medical appeal and 866-241-0365 for a pharmacy appeal, or fax us at 1-724-741-4953 for a medical appeal and 1-724-741-4954 for a pharmacy appeal. If your request for a fast appeal is filed verbally, written notice is not needed.

If we decide you need a fast appeal, we will call you with our decision. We will do this within 72 hours after receiving your fast appeal. We will also send you a Notice of Plan Appeal Resolution (NPAR) letter with our decision. If you ask for a fast appeal and we decide that one is not needed, we will:

- Change the appeal to the time frame for a standard decision (30 calendar days)
- Call you the same day we decide a fast appeal is not needed to tell you about our denial of your fast appeal request
- Follow up with a written letter within two calendar days
- Tell you over the phone and in writing that you may file a grievance about the denial of your fast appeal request

Additional Information

You or someone appealing for you can give us more information if you feel it will help your appeal. You can do this at any time during the appeal process.

For a standard appeal, you can ask us for up to 14 more calendar days to provide more information. If we think it's in your best interest, we may ask for 14 more calendar days to make a decision on a standard appeal. If we need more time, we will call you to tell you that additional time is needed. We will also send you a letter within two calendar days telling you why we are requesting more time.

Additional Appeals Assistance

If you are not happy with our appeal decision, you have a couple of options available to you. You can request a Medicaid Fair Hearing.

Medicaid Fair Hearing

You can ask for a Medicaid Fair Hearing (MFH). You must have completed the plan's appeal process before you can ask for a Medicaid Fair Hearing. You can request a MFH within 120 calendar days of receiving the Notice of Plan Appeal Resolution from the plan.

To request a Medicaid Fair Hearing review of the plan's appeal decision, submit a request for review to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906

Phone: 877-254-1055 (toll-free)
Fax: 239-338-2642
Email: MedicaidHearingUnit@ahca.myflorida.com

You have to complete the plan's appeal decision process before submitting a request fot a Medicaid Fair Hearing.

Continuation of Benefits During the Appeals Process

You can ask that we continue to cover your medical services while your appeal is pending for a decision.

To continue medical services for a pending appeal decision you must meet the following conditions:

- You must file your appeal with us within 10 calendar days of our mailing the Notice of Adverse Benefit Determination (NABD) to you or on or before the first day that the service will be reduced, suspended or stopped, whichever is later
- Your appeal involves an action we are taking to reduce, suspend or stop a service we had already approved
- The service must have been ordered by an authorized provider
- The original time period covered by the approval we gave has not yet ended
- You need to ask for a continuation of benefits

If you meet all of the conditions as outlined above, we will continue your benefits until one of the following happens:

- You withdraw your appeal;
- 10 days pass after we send you the notice of resolution of the appeal against you, unless you have asked for a Medicaid Fair Hearing with continuation of benefits in those 10 days; or
- The time period or service limits of the previously authorized service have been met

Continuation of Benefits during Medicaid Fair Hearings

To ask for benefits to continue during a Medicaid Fair hearing, you must:

- Request a fair hearing within ten (10) calendar days after the Notice of Plan Appeal Resolution is mailed, or on or before the intended effective date of the proposed action, whichever is later

The plan will not suspend, terminate or reduce services until a decision is rendered after the Medicaid Fair Hearing.

What if the Medicaid Fair Hearing officer rules against the plan's action?
If we did not provide the services you wanted during the appeal, we will approve them no later than 72 hours from the date when we receive notice to change the appeal decision. If you did receive the services during the appeal, we will pay for them.

What if the officer rules in favor of the plan's action?
In this case, you may have to pay for services you received.

Chapter 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Aetna Medicare Assure Plus (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your costs share until your membership ends.

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
  - Another Medicare health plan with or without prescription drug coverage
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare without a separate Medicare prescription drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without "creditable" prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

  Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in **Addendum A** at the back of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

OR

  - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period.**

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 the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.
Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period,** please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
  - Another Medicare health plan with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

OR

  - Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

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

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Services.**
- Find the information in the ***Medicare & You 2023*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Aetna Medicare Assure Plus (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from Aetna Medicare Assure Plus (HMO D-SNP) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan ◦ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. ◦ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Aetna Medicare Assure Plus (HMO D-SNP) when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your FL State Medicaid benefits, contact the Medicaid office. See **Addendum A** at the back of this document for the contact information. Ask how joining another plan or returning to Original Medicare affects how you get your FL State Medicaid coverage.

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

Until your membership in Aetna Medicare Assure Plus (HMO D-SNP) ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Aetna Medicare Assure Plus (HMO D-SNP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Aetna Medicare Assure Plus (HMO D-SNP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B

- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. Our plan will continue to cover your Medicare benefits for a grace period of up to six (6) months if you lose Medicaid eligibility. This grace period begins the first day of the month after we learn of your loss of eligibility and communicate that to you. If at the end of the six (6) month grace period you have not regained Medicaid and you have not enrolled in a different plan, we will disenroll you from our plan and you will be enrolled back in Original Medicare.
- If you move out of our service area
- If you are away from our service area for more than six months
  - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?
If you have questions or would like more information on when we can end your membership call Member Services.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Aetna Medicare Assure Plus (HMO D-SNP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?
If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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

Chapter 11:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or 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 law are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

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

The plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the Federal statutes governing the Medicare Program. Your Medicare Advantage plan coverage is always secondary to any payment made or reasonably expected to be made under:

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

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

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

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

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

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

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

damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your Medicare Advantage plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

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

SECTION 4 Notice about recovery of overpayments

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

SECTION 5 National Coverage Determinations

Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2023, either Medicare or our plan will cover those services. When we receive coverage updates from Medicare, called National Coverage Determinations, we'll post the coverage updates on our website at AetnaMedicare.com. You can also call Member Services to obtain the coverage updates that have been posted for the benefit year.

Chapter 12:
Definitions of important words

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

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

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

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

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,400 in covered drugs during the covered year.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

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

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

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

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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

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

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

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals 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 individual's eligibility.

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 are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a preferred lower cost-sharing level (a tiering exception). You may also request an exception if our plan sponsor requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

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

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

Home Health Aide – A person who provides services that do not 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. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Independent Practice Associations (IPA) – 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.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $4,660.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. 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.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (**Note:** Because our members also get assistance from Medicaid, very few members ever reach this out of pocket maximum.)

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not 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 the 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 Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

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

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

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

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

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

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 two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

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

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

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

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

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

Primary Care Provider (PCP) – 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 or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

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

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

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where 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. The plan must disenroll you if you permanently move out of the plan's service area.

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

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

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

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

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

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Addendum A – Important Contact Information for State Agencies

	Quality Improvement Organizations (QIO)
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**KEPRO**, **Address:** 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, **Phone:** 1-888-317-0751, **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, **Website:** keproqio.com

	State Medicaid Office
FL	**Florida Agency for Health Care Administration, Division of Medicaid**, **Address:** 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308, **Phone:** 1-850-412-4000, **TTY:** 1-800-955-8771, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ahca.myflorida.com/Medicaid/index.shtml

	State Health Insurance Assistance Program (SHIP)
FL	**Serving Health Insurance Needs of Elders (SHINE)**, **Address:** 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, **Phone:** 1-800-963-5337, **TTY:** 1-800-955-8770, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridashine.org/

	State AIDS Drug Assistance Programs (ADAP)
FL	**Florida AIDS Drug Assistance Program (ADAP)**, **Address:** HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, **Phone:** 1-800-352-2437, 850-245-4422, **TTY:** 1-888-503-7118, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** floridahealth.gov/diseases-and-conditions/aids/adap/

	Ombudsman
FL	The Long Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families. **Florida's Long-Term Care Ombudsman Program**, **Address:** 4040 Esplanade Way, Tallahassee, FL 32399-7000, **Phone:** 1-888-831-0404, 850-414-2323, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** ombudsman.elderaffairs.org/

Aetna Medicare Assure Plus (HMO D-SNP) Member Services

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

State Health Insurance Assistance Program (SHIP)
SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **Addendum A** at the back of this document.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-409-1221. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-409-1221. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-409-1221。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-409-1221。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-409-1221. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-409-1221. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-409-1221. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-409-1221. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-409-1221. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-409-1221. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-409-1221 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-409-1221. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-409-1221. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-409-1221. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-409-1221. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-409-1221. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-409-1221. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-866-409-1221. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.