

January 1 – December 31, 2024

Evidence of Coverage:

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-855-344-2209. (TTY users should call 711). Hours are 8 AM to 9 PM ET, Monday through Friday. This call is free.

This plan, Aetna Medicare Plan (PPO), is offered by Aetna Medicare. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Aetna Medicare. When it says “plan” or “our plan,” it means Aetna Medicare Plan (PPO).)

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

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.

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Participating 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.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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CHAPTER 1:

Getting started as a member

Chapter 1 Getting started as a member**SECTION 1 Introduction****Section 1.1 You are enrolled in Aetna Medicare Plan (PPO), which is a Medicare PPO**

Your coverage is provided through a contract with your former employer/union/trust. You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Aetna Medicare Plan (PPO). 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 Plan (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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 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 Plan (PPO).

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 Plan (PPO) 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 Plan (PPO) between January 1, 2024 and December 31, 2024.

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 Plan (PPO) after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Aetna Medicare Plan (PPO) each year. Your former employer/union/trust can continue to offer you 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 2.2 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 eligibility requirements of your former employer/union/trust

Section 2.2 Here is the plan service area for Aetna Medicare Plan (PPO)

Aetna Medicare Plan (PPO) 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 in **Addendum B** at the back of this document. Your coverage is offered through an extended service area (ESA) feature which allows you to be covered in the areas that are not listed as an Aetna network service area.

If you plan to move out of the service area, you will have a Special Enrollment Period that will allow you to switch to a different plan. Please contact your former employer/union/trust plan administrator to see what other plan options are available in your new location.

If you move, please contact Member Services at the telephone number printed on your member ID card.


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 2.3 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 Plan (PPO) if you are not eligible to remain a member on this basis. Aetna Medicare Plan (PPO) 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, if applicable. Here's a sample membership card to show you what yours will look like:

 Medicare Plan Type PLAN NAME LINE 1 PLAN NAME LINE 2 PLAN# 000000-00XX0000 ID 10XXXXXXXXXX NAME SAMPLE SAMPLETON RxBIN 610502 RxPCN MEDDAET RxGRP# RXAETD ISSUER (80840) Printed on: XX/XX/XXXX PCP \$XX ER \$XX AS \$XX HO \$XX/X SP \$XX HXXXX-PBP	Website Customer Service 1-XXX-XXX-XXXX Prescription Drug 1-XXX-XXX-XXXX 24 Hour Nurse Line 1-XXX-XXX-XXXX Provider Services 1-XXX-XXX-XXXX TDD/TTY 711 Send claims to: Claims PO Box XXXXX City, State, Zip This card does not guarantee coverage. Payer ID# 60054
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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 Plan (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine 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 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers. You are a member of our plan through our extended service area (ESA) feature. Aetna Medicare may or may not have a provider network where you live. **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. 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 Plan (PPO) authorizes use of out-of-network providers.

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

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 3.3 Pharmacy Directory

The *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 *Pharmacy Directory* to find the network pharmacy 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.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing (if included in your plan), which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services. You can also find this information on our website at Dow.AetnaMedicare.com.

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 Plan (PPO). 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 Plan (PPO) 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 (Dow.AetnaMedicare.com) or call Member Services.

SECTION 4 Your monthly costs for Aetna Medicare Plan (PPO)

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

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

If you 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 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.

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 2024* handbook, the section called *2024 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 our plan, you may pay a monthly plan premium. Please contact your plan benefits administrator for information about your plan premium (if applicable).

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 (if applicable), **you must continue paying 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.

Chapter 1 Getting started as a member

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there 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 Plan (PPO), we will 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 Veteran Affairs. Your insurer or 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:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. 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 2024, this average premium amount is \$34.70.
- 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 \$34.70, which equals \$4.86. This rounds to \$4.90. 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 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 because of your income, 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

For most members, your plan benefits administrator will provide you with information about your plan premium (if applicable). If Aetna bills you directly for your total plan premium, we will mail you a **monthly invoice** detailing your premium amount.

For members who have an Aetna plan premium and are billed directly by Aetna, there are four ways you can pay your plan premium. You may inform us of your premium payment option choice or change your choice by calling Member Services.

Option 1: Paying by check

If you did not select a payment option on our enrollment application at the time you enrolled in our plan, we will automatically set you up on the **invoice method** so that you can make your payments by check. You may decide to pay your monthly plan premium to us by check using our invoice method. Please make your checks payable to our plan (which is indicated on your invoice) not to CMS nor HHS. Monthly plan premium payments are due the 1st day of each month for coverage of the current month. We must receive your check and corresponding month's invoice slip in our office by the 10th of each month to prevent your account from becoming delinquent. All monthly plan premium payments should be sent to the address listed on your payment invoice.

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

Option 2: Paying at a CVS Pharmacy

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

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

Option 3: Paying by automatic withdrawal

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

- To enroll in this program online, go to [AetnaMedicare.com/PayBill](https://www.aetna.com/membership/paybill). Select the following deduction options: "on due date" and "amount due".
- Alternatively, you may contact Member Services or complete and return the authorization form located on your premium invoice. Your plan premium will be automatically deducted from your bank account between the 10th and the 15th of each month unless it is a weekend or bank holiday, then the deduction will occur the next business day. By selecting this payment option, you will no longer receive an invoice.

Option 4: Using your credit/debit card or via e-check

You may pay your plan premium each month by using your credit/debit card or checking account. Please remember all premiums are due on the first of the month.

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

Changing the way you pay your plan premium.

If you decide to change the option by which you pay your plan 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 payment method, please contact Member Services.

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

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

Section 5.2	Can we change your monthly plan premium during the year?
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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 prior to the date your plan renews and the change will take effect on the date your plan renews.

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.

If your plan does not require you to pay a plan premium, however, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty. This could happen if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for “Extra Help” during the year, you would be able to stop paying your penalty.
- 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.

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 or domestic partner’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 you have with your

Chapter 1 Getting started as a member

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 or domestic partner 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, employer group health plans, and/or Medigap have paid.

CHAPTER 2: *Important phone numbers and resources*

SECTION 1 Aetna Medicare Plan (PPO) 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 Plan (PPO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	Please call 1-855-344-2209 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. 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 9 PM ET, Monday through Friday.
FAX	1-866-474-4040
WRITE	Aetna Medicare PO Box 7082 London, KY 40742
WEBSITE	Dow.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 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	Please call 1-855-344-2209 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
FAX	1-866-759-4415
WRITE	Aetna Medicare Precertification Unit PO Box 14079 Lexington, KY 40512
WEBSITE	Dow.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 Coverage Determinations PO Box 7773 London, KY 40742
WEBSITE	Dow.AetnaMedicare.com

Method	Appeals for Medical Care – Contact Information
CALL	Please call 1-855-344-2209 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
FAX	Expedited appeals: 1-724-741-4958 Standard appeals: 1-724-741-4953
WRITE	Aetna Medicare Part C Appeals PO Box 14067 Lexington, KY 40512
WEBSITE	Dow.AetnaMedicare.com

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 Part D Appeals PO Box 14579 Lexington, KY 40512
WEBSITE	Dow.AetnaMedicare.com

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	Please call 1-855-344-2209 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
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 Plan (PPO) 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	Please call 1-855-344-2209 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
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 Plan (PPO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

Where to send a request asking for us to pay for 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 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	Dow.AetnaMedicare.com

Method	Payment Requests for Part D Prescription Drugs – Contact Information
FAX	1-480-314-6844
WRITE	Aetna Pharmacy Management PO Box 52446 Phoenix, AZ 85072-2446
WEBSITE	Dow.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.

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 Plan (PPO):

- **Tell Medicare about your complaint:** You can submit a complaint about Aetna Medicare Plan (PPO) 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** at the back of this document for the name and contact information for 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 plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES

- Visit www.shiphelp.org (click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. 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. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and its programs, contact your state Medicaid agency. Refer to **Addendum A** at the back of this document for the name and contact information for the Medicaid agency 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

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. If you qualify, you 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.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "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 (applications); or
- Your State Medicaid Office (applications). (See **Addendum A** at the back of this document for

contact information.)

If you believe you have qualified for “Extra Help” and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows 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:

- While you are at the pharmacy, you can ask the pharmacist to contact Aetna at the number on your member ID card. If the situation cannot be resolved at that time, Aetna will give you a one-time exception and you will be charged the copayment/coinsurance amount that you were given by CMS. This exception is temporary and lasts 21 days. Aetna will permanently update our systems upon the receipt of one of the acceptable forms of evidence.

Method	Best Available Evidence – Contact Information
WRITE	Aetna Medicare Department Attention: BAE PO Box 14088 Lexington, KY 40512-4088
FAX	1-888-665-6296
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 a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than “Extra Help”), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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 covered by ADAP 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. (Refer to **Addendum A** at the back of this document for the name and contact information of the ADAP in your state).

State Pharmaceutical Assistance Programs

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

Refer to **Addendum A** at the back of this document for the name and contact information of the State Pharmaceutical Assistance Program 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 <i>not</i> free.
WEBSITE	rrb.gov/

SECTION 9 Do you have group insurance or other health insurance from another employer/union/trust?

Your Aetna coverage is provided through a contract with your former employer/union/trust. You (or your spouse or domestic partner) may also get medical coverage from another employer or retiree group. Call the benefits administrator if you have questions regarding coordination of your coverages. You can also call Aetna Member Services if you have any questions. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:

Using the plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the *Schedule of Cost Sharing*. It's described 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 their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the *Schedule of Cost Sharing*. Your covered services for prescription drugs are discussed in the *Prescription Drug Schedule of Cost Sharing*.

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

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

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

- **The care you receive is included in the plan's *Schedule of Cost Sharing*** (this chart is provided by mail).
- **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 receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *Provider Directory*.
 - Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

Section 2.1

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

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

As a member of our plan, you do not have to choose a network PCP; **however, we strongly encourage you to choose a PCP and let us know who you chose.** Your PCP can help you stay healthy, treat illnesses and coordinate your care with other health care providers. If you choose a network PCP, they will appear on your member ID card. If your member ID card does not show a PCP (or PCP office) or the one you want to use, please contact us so we can update our files.

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

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

Please refer to your *Provider Directory* or go to our website at Dow.AetnaMedicare.com 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.

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

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

How do you choose your PCP?

You can select your PCP by using the *Provider Directory*, by accessing our website at Dow.AetnaMedicare.com, or getting help from Member Services. You can change your PCP for any reason, at any time by contacting Member Services.

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.

Section 2.2 How to get care from specialists and other network providers

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

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

Prior authorization process

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

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

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 notify you that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
 - If any of your other providers leave our plan, we will notify you if you are assigned to the

provider, currently receive care from them, or have seen them within the past three months.

- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. 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 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See 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 if you receive a bill or if you need to ask for reimbursement.
- As a member of our plan, you may use network providers or out-of-network providers for all covered medical services at the same member cost-sharing amount. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically

necessary. If you don't have your copy of the *Provider Directory*, and you reside in a network service area, you can request a copy from Member Services. A listing of network service areas is available in **Addendum B** at the back of this booklet. If you do not reside in a network service area, but you will be visiting a network service area in the future, you may still request a directory from us.

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
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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 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.

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 wherever 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.

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 *Schedule of Cost Sharing* 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.

- **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 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.

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.

In addition, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will be the same whether you get the care from network providers or out-of-network providers.

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 Directory*, going to our website at [Dow.AetnaMedicare.com](https://www.dow.aetna.com), or getting help from Member Services.

Our plan covers worldwide emergency and urgent care 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 *Schedule of Cost Sharing* 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: [Dow.AetnaMedicare.com](https://www.dow.aetna.com) for information on how to obtain needed care during a disaster. 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 covered services?

Section 4.1 You can ask us to pay our share of the cost of 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 If services are not covered by our plan, you must pay the full cost

Aetna Medicare Plan (PPO) covers all medically necessary services as listed in the *Schedule of Cost Sharing*. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you 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 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 a Medicare-approved clinical research study, you do *not* need to tell us or 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. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determination (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study covered for Medicare Advantage enrollees by Original Medicare, 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, Original Medicare covers the 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

Chapter 3 Using the plan for your medical services

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 limits may apply. See the *Schedule of Cost Sharing*

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 Plan (PPO) we will transfer ownership of certain DME items. Call Member Services to find out about the requirements you must meet and the documentation you need to provide.

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 and then joined our plan. The payments you made 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 consecutive payments for the 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
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What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Aetna Medicare Plan (PPO) will cover:

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

If you leave Aetna Medicare Plan (PPO) 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 services 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 (*Schedule of Cost Sharing*) that lists your covered services and shows how much you will pay for each covered service as a member of Aetna Medicare Plan (PPO). 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.

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 and the *Schedule of Cost Sharing* tell you more about your plan deductible.)
- **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 *Schedule of Cost Sharing* 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 *Schedule of Cost Sharing* tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is your plan deductible?

Your deductible (if applicable) is shown in the *Schedule of Cost Sharing*. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. Refer to the *Schedule of Cost Sharing* for a full list of services that are not subject to the plan deductible.

Section 1.3 What is the most you will pay for covered medical services?

Under our plan, there is a limit on what you have to pay out-of-pocket for covered medical services. This amount is shown in the *Schedule of Cost Sharing*.

- Your **combined maximum out-of-pocket amount** is listed in the *Schedule of Cost Sharing*. This is the most you pay during the calendar year for covered plan services received from both in-network and out-of-network providers. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums (if applicable) and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the *Schedule of Cost Sharing*.) If you have paid the combined maximum out-of-pocket amount listed in the *Schedule of Cost Sharing* for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered

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

services. However, you must continue to pay your plan premium (if applicable) and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4	Our plan does not allow providers to balance bill you
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As a member of Aetna Medicare Plan (PPO), an important protection for you is that after you meet any deductibles (if applicable), 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.
 - 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.
- If you believe a provider has balance billed you, call Member Services.

SECTION 2	Use the <i>Schedule of Cost Sharing</i> to find out what is covered and how much you will pay
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Section 2.1	Your medical benefits and costs as a member of the plan
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The *Schedule of Cost Sharing* lists the services Aetna Medicare Plan (PPO) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5, in addition to the *Prescription Drug Schedule of Cost Sharing*. The services listed in the *Schedule of Cost Sharing* are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- 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
- Some of the services listed in the *Schedule of Cost Sharing* are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Aetna Medicare Plan (PPO).
 - Covered services that need approval in advance to be covered as in-network services are

marked by a note in the *Schedule of Cost Sharing*.

- You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* 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. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you 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 5.3 in this document.)

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		<p>Available for people with chronic low back pain under certain circumstances.</p> <p>Additional coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i>.</p>
Cosmetic surgery or procedures		<ul style="list-style-type: none"> • 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.
<p>Custodial care</p> <p>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.</p>	Not covered under any condition	
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.</p>		<p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition	
Full-time nursing care in your home.	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals		Some coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i> .
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.		Some coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i> .
Naturopath services (uses natural or alternative treatments).	Not covered under any condition	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. Additional coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i> .
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition	

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		<p>Manual manipulation of the spine to correct a subluxation is covered.</p> <p>Additional coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i>.</p>
Routine dental care, such as cleanings, fillings or dentures.		<p>Coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i>.</p>
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		<p>Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.</p> <p>Additional coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i>.</p>
Routine foot care		<p>Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).</p> <p>Additional coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i>.</p>
Routine hearing exams, hearing aids, or exams to fit hearing aids.		<p>Some coverage may be provided by your former employer/union/trust. See your <i>Schedule of Cost Sharing</i>.</p>
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition	

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

Chapter 5 Using the plan's coverage for your Part D prescription drugs**SECTION 1 Introduction**

This chapter **explains rules for using your coverage for Part D drugs**. Please see the *Schedule of Cost Sharing* for Medicare Part B drug benefits and hospice drug benefits.

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 references. (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 covered 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 *Pharmacy Directory*, visit our website ([Dow.AetnaMedicare.com](https://www.dow.aetna.com)), and/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 at a pharmacy that offers standard cost sharing (if included in your plan). The *Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing (if included in your plan). 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. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing (if included in your plan), you may want to switch to a different pharmacy. To find another network pharmacy in your area, you can get help from Member Services or use the *Pharmacy Directory*. You can also find information on our website at [Dow.AetnaMedicare.com](https://www.dow.aetna.com).

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care 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 *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. The drugs available through our plan's mail-order service are marked as **mail-order (MO) drugs** in our "Drug List".

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail from our preferred mail-order pharmacy, contact Member Services (phone numbers are printed on your member ID card).

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 receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and 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

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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 need 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 contact us by calling Member Services.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4	How can you get a long-term supply of drugs?
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When you get a long-term supply of drugs, your cost sharing may be lower. 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". (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 *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?
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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.

In these situations, when you are covered to fill your prescription at an out-of-network pharmacy, you may be limited to a 30-day supply of your drug.

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 (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (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 drugs on the "Drug List" are only those covered under Medicare Part D.

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 or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for 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 our "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

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Chapter 9.

Section 3.2 There are different cost-sharing tiers for drugs on the "Drug List"

Every drug on the plan's "Drug List" is in a cost-sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Your tier structure will be one of the following:

Drug Tier	Three Tier Plan	Four Tier Plan	Five Tier Plan
Tier 1	Generic Drugs	Generic Drugs	Preferred Generic Drugs
Tier 2	Preferred Brand Drugs*	Preferred Brand Drugs*	Generic Drugs
Tier 3	Non-Preferred Drugs*/Non-Preferred Brand Drugs	Non-Preferred Drugs*/Non-Preferred Brand Drugs	Preferred Brand Drugs*
Tier 4		Specialty Drugs	Non-Preferred Drugs*/Non-Preferred Brand Drugs
Tier 5			Specialty Drugs

*Depending on plan type and formulary, in some instances tiers noted with a * may include both brand and higher cost generic drugs. See your *Prescription Drug Schedule of Cost Sharing* for details on your plan coverage.

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

The tier structure for your plan and the amount you pay for covered prescription drugs in each cost-sharing tier is shown in the *Prescription Drug Schedule of Cost Sharing*.

Section 3.3 How can you find out if a specific drug is on the "Drug List"?

You have four ways to find out:

1. Check the most recent "Drug List" we provided electronically.
2. Visit the plan's website ([Dow.AetnaMedicare.com](https://www.dow.aetna.com)). 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.
4. Use the plan's "Real-Time Benefit Tool" by logging into the member portal at [Dow.AetnaMedicare.com](https://www.dow.aetna.com). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

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 ways. 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 drugs, 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 drug when a generic version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version of the brand name drug or original biological product.** However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for you *OR* has written “No substitutions” on your prescription for a brand name drug or original biological product *OR* has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

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, 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.

Chapter 5 Using the plan's coverage for your Part D prescription drugs**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
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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.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- 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.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 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?
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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 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 temporary coverage (up to a 31-day supply) for the 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 might 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 for you 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 6.4 tells you 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 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 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.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the

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cost-sharing amount for drugs in the Preferred tiers, for any drug in the Specialty tier, or any drugs in Tier 1. Coverage of any non-formulary drug is not eligible for a tiering exception. Also, drugs included under a Non-Part D supplemental benefit are not eligible for a tiering exception. (Non-Part D supplemental benefit coverage is purchased by some former employer/union/trust plans to cover some prescription drugs not normally covered in a Medicare prescription drug plan. If included, this will be identified in your *Prescription Drug Schedule of Cost Sharing* under the section "Non-Part D Supplemental Benefit.")

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 might make changes to the "Drug List". For example, the plan might:

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

We must follow Medicare requirements before we change 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 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 provider 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 drugs on 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 move your drug into a higher cost-sharing tier.
- We put a new restriction on your use of the 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 restriction 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 get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs that may be covered under your plan's Non-Part D supplemental benefit coverage). 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.)

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

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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, these categories of drugs are not covered by Medicare drug plans:

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

Your former employer/union/trust may purchase supplemental coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (Non-Part D supplemental benefit). If included, this will be identified in your *Prescription Drug Schedule of Cost Sharing* under the section "Non-Part D Supplemental Benefit." The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)

In addition, if you are **receiving "Extra Help"** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. 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

Section 8.1 Provide your membership information

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 *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

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, or you can ask the pharmacy to look up your plan enrollment 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** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
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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.

Section 9.2	What if you're a resident in a long-term care (LTC) facility?
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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 *Pharmacy Directory* to find out if your LTC facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services. If you are in a 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 also getting drug coverage from another employer/union/trust retiree group plan?
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If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

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

Special note about creditable coverage:

If you are covered by another employer/union/trust retiree group plan, each year that employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

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

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Chapter 5 Using the plan's coverage for your Part D prescription drugs**Section 9.4 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 drugs, laxatives, pain medication or anti-anxiety 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 may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain

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 tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. 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 decision 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 new 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) program to help members manage their medications
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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. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will 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 from the program. If you have any questions about this program, please contact Member Services.

CHAPTER 6: *What you pay for your Part D prescription drugs*

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction**Section 1.1 Use this chapter together with other materials that explain your drug coverage**

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use drug in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by our plan if your former employer/union/trust has purchased supplemental drug coverage through a Non-Part D Supplemental Benefit. See the *Prescription Drug Schedule of Cost Sharing* for more information.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explains these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Member Services.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing**, and there are three ways you may be asked to pay.

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

Section 1.3 How Medicare calculates your out-of-pocket costs

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

These payments are included in your out-of-pocket costs

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

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Deductible Stage, if applicable to your plan
 - The Initial Coverage Stage
 - The Coverage Gap Stage

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$8,000 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium (if applicable).
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan (if purchased by your former employer/union/trust plan).
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches a total of \$8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure

that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Aetna Medicare Plan (PPO) members?

There are four **drug payment stages** for your prescription drug coverage under Aetna Medicare Plan (PPO). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 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 and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **out-of-pocket** cost.
- 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 information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 3.2 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.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - 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 a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. 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.

SECTION 4 During the Deductible Stage, you pay the full cost of your Part D drugs

If your plan includes a deductible, the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription for the year. Your plan's deductible amount (if applicable) is listed in the *Prescription Drug Schedule of Cost Sharing*. **You must pay the full cost of your drugs on tiers that the deductible applies** until you reach the plan's deductible amount. The deductible, if applicable, does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. The **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid your plan deductible amount (if applicable), for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

If your plan does not include a deductible, this payment stage does not apply to you. You begin in the Initial Coverage Stage when you fill your first prescription of the year.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has a number of cost-sharing tiers

Every drug on the plan's "Drug List" is in one of a number of cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug. The tier structure for your plan is listed in the

Prescription Drug Schedule of Cost Sharing.

- You will not pay more than \$35 per one-month supply of each covered insulin product regardless of tier. If your plan includes a deductible, it will not apply to any covered insulin product.

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

Your pharmacy choices

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

- A network retail pharmacy that offers standard cost sharing
- A network retail pharmacy that offers preferred cost sharing (if included in your plan). Costs may be less at pharmacies that offer preferred cost sharing.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory*.

Section 5.2	Refer to your <i>Prescription Drug Schedule of Cost Sharing</i> for your costs for a one-month supply of a drug
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During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table in the *Prescription Drug Schedule of Cost Sharing*, the amount of the copayment or coinsurance depends on the cost-sharing tier.

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

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible, if applicable.

Please see Section 8 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

Section 5.3	If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply
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Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the

coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.

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

Section 5.4	Refer to your <i>Prescription Drug Schedule of Cost Sharing</i> for a table that shows your costs for a <i>long-term</i> (up to a 90-day) supply of a drug
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For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply.

Refer to your *Prescription Drug Schedule of Cost Sharing* for a table that shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.
- You won't pay more than \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible, if applicable.

Section 5.5	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$5,030
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You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **\$5,030 limit for the Initial Coverage Stage**.

Your former employer/union/trust may purchase additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. If included in your plan, this will be listed in your *Prescription Drug Schedule of Cost Sharing* under the section "Non-Part D Supplemental Benefit." The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf for your drugs during the year. Many people do not reach the \$5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

The amount of your cost sharing during the Coverage Gap Stage is shown in the *Prescription Drug Schedule of Cost Sharing*.

Medicare Coverage Gap Discount Program

Brand drugs during the Coverage Gap Stage:

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. If your plan does not include supplemental coverage for brand drugs you pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. Your cost for brand

name drugs in the coverage gap is shown in the *Prescription Drug Schedule of Cost Sharing*.

Generic drugs during the Coverage Gap Stage:

You also receive some coverage for generic drugs. If your plan does not include supplemental coverage for generic drugs, you pay no more than 25% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. If your plan does include supplemental coverage for generic drugs, you will pay the applicable plan cost share for the cost-sharing tier, and the amount you pay counts and moves you through the coverage gap. Your cost for generic drugs in the coverage gap is shown in the *Prescription Drug Schedule of Cost Sharing*.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount \$8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
- For excluded drugs covered under a non-Part D supplemental benefit, if included in your plan, you pay the amount listed in the *Prescription Drug Schedule of Cost Sharing* under the section "Non-Part D Supplemental Benefit".

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines — Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the *Schedule of Cost Sharing*. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List". Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible (if applicable). Refer to your plan's "Drug List" or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depends on three things:

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

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

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

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

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

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

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

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

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

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

Please note: Certain vaccines, such as Zostavax (shingles vaccine) are covered under Part D. For vaccines covered under Part D, please refer to your "Drug List". If you have any questions about how your vaccine is covered, you can call Member Services.

CHAPTER 7:

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

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 our share of the cost of your covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, 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.

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 medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. Ask the provider to bill the plan for our share of the cost.

- 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 of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

2. When a network provider sends you a bill you think you should not pay

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

- You only have to pay your cost-sharing amount when you get covered services covered by our plan. 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.
- 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 and ask us to pay you back 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 costs. 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 for our share of the cost.

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 "Drug List"; 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 our share of the cost.

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

All of the examples above are types of coverage decisions. This means that 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 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 ([Dow.AetnaMedicare.com](https://www.aetna.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 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
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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. If you have already paid for the service or drug, we will mail your reimbursement of 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

Chapter 7 Asking us to pay our share of a bill you have received for covered medical services or drugs

not pay for our share of the cost. 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
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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.)
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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 specialties 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 at the number on your member ID card. 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.)
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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
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You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

If you think 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
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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 your 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

Chapter 8 Your rights and responsibilities

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 Plan (PPO), 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 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 of this document (and the *Schedule of Cost Sharing*) provide information regarding medical services. Chapters 5 and 6 (and the *Prescription Drug Schedule of Cost Sharing*) provide 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 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 as well. 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

Chapter 8 Your rights and responsibilities

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 State Health Insurance Assistance Program (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
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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?
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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, gender identity, 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).

Section 1.8	How to get more information about your rights
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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 (and the *Schedule of Cost Sharing*) give the details about your medical services.
 - Chapters 5 and 6 (and the *Prescription Drug Schedule of Cost Sharing*) give the details about your coverage for 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 (if applicable).
 - You must continue to pay your Medicare Part B to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* 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)*

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 two types of processes for handling problems and concerns:

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

Both of 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 make things easier, 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 customer service 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** at the back of this document.

Medicare

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

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

- 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).

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS**SECTION 4 A guide to the basics of coverage decisions and appeals****Section 4.1 Asking for coverage decisions and making appeals: the big picture**

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

Asking for coverage decisions prior to receiving benefits

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

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care 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, whether before or after a benefit is received, 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 the rules. When we have completed the review, we give you our decision. 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 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 say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal. 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 6 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 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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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 (SHIP).
- **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 or Part B prescription drugs, 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 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 (phone numbers are printed on your member ID card) 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

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

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 4.3	Which section of this chapter gives the details for your situation?
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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 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 6** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal
- **Section 7** 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 8** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which 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 (SHIP).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1	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
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This section is about your benefits for medical care. These benefits are described in the Medical Benefits Chart (*Schedule of Cost Sharing*). 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 is covered by our plan. **Ask for a coverage decision. Section 5.2.**
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 5.2.**
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 5.3.**
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 5.5.**

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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 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2	Step-by-step: How to ask for a coverage decision
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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 items and/or services (*not requests for payment for items and/or services already 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 the 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 that if your doctor asks for the fast 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 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.

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- **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 the decision. (The process for making a complaint is different than the process for coverage decisions and appeals. See Section 10 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 10 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 5.3	Step-by-step: How to make a Level 1 appeal
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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 or 7 days for Part B drugs. 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 5.2 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.

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- **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 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 our plan is reviewing your appeal, we take a 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.
 - 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 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 5.4 explains the Level 2 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 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the

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coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a 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 5.4 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. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We 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.
- However, 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.
- However, 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 review organization says yes to part or all of a request for a medical item or service**, we

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must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.

- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care 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 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 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?
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Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you 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 is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, 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 medical care 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:

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

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

Section 6.1 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 Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term “Drug List” instead of *List of Covered Drugs* or *Formulary*.

- If you 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 6.2**
- 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 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

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

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

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

Section 6.2

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”.** If we agree to cover a drug not on the “Drug List”, you will need to pay the cost-sharing amount that applies to drugs in the Specialty drug tier. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
- 2. Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our “Drug List”. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

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3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our “Drug List” is in one of our 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 biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- 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 the Specialty drug cost-sharing tier (if applicable to your plan).
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can’t take, you will usually pay the lowest amount.
- Coverage of any non-formulary drug is not eligible for a tiering exception.
- A drug included under a non-Part D supplemental benefit is not eligible for a tiering exception. (Non-Part D supplemental benefit coverage is purchased by some former employer/union/trusts to cover some prescription drugs not normally covered in a Medicare prescription drug plan. If included, this will be identified in your *Prescription Drug Schedule of Cost Sharing* under the section “Non-Part D Supplemental Benefit.”)

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons Your doctor or other prescriber must give us a statement that explains the medical reasons 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, 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 for an exception, you can ask for a review by making an appeal.

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

Section 6.4

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**.

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

Standard coverage decisions are made within **72 hours** after we 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 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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form which is available on our website. 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 give you our answer.

Deadlines for a fast coverage decision

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

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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 or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Coverage 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 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 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 to.
 - 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

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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 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 **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 6.6	Step-by-step: How to make a Level 2 appeal
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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.

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- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it 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 a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are

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

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 also 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 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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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 the 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 7.2	Step-by-step: How to make a Level 1 appeal to change your hospital discharge date
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Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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 (SHIP), 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 **Addendum A**.

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 7.4.
- 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

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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 7.3	Step-by-step: How to make a Level 2 appeal to change your hospital discharge date
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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 Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

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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. This is called “upholding the decision.”
- 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4	What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?
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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 date. 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

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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 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 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 our plan 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 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 10 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 have 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 with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

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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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 8.1 *This section is only about three services:*
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it 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 8.2 We will tell you in advance when your coverage will be ending

Legal Term

Notice of Medicare Non-Coverage. It tells you 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. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a fast track appeal to request us to keep covering your care for a longer period of time.
- 2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you 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.

Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 8.3****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 (SHIP), 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.

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

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

How can you contact this organization?

- The written notice you 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 **Addendum A** at the back of this document.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline 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 8.5.

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.

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- 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 8.4

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?

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- **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 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 our Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5

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.

- **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 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

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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 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 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 10 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 9 in

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this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 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 a 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 medical care 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 medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept 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 medical care 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 might 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

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

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 9.2 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 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.

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MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?

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Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> You asked us 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 the deadlines for covering or reimbursing you for certain medical items, services, or drugs that were approved; you can make a complaint. You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal 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 10.3 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

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your complaint and our decision in clear terms.

- We must address your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if we justify a need for additional information and the delay is in your best interest.
- You also have the right to ask for a fast “expedited” grievance. A fast “expedited” grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a fast “expedited” grievance if you disagree with:
 - Our plan to take a 14-calendar-day extension on an organization/coverage determination or reconsideration/redetermination (appeal); or
 - Our denial of your request to expedite an organization determination or reconsideration (appeal) for health services or;
 - Our denial of your request to expedite a coverage determination or redetermination (appeal) for a prescription drug.
- The fast “expedited” grievance process is as follows:
 - You or an authorized representative can call, fax, or mail your complaint and mention that you want the fast complaint or expedited grievance process. Call the phone number, fax, or write your complaint and send it to the address listed in Chapter 2: *Important Phone Numbers and Resources (How to contact us when you’re making a complaint about your Part D prescription drugs or medical care)*. The fastest way to submit a fast complaint is to call or fax us. The fastest way to file a grievance is to call us. When we receive your complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-calendar-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will investigate your complaint and notify you of our decision within 24 hours.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem that you want to complain about.

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

- **If possible, we 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 10.4 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. **Addendum A** has the contact information.

Or

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

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

Section 10.5	You can also tell Medicare about your complaint
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You can submit a complaint about Aetna Medicare Plan (PPO) 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.

CHAPTER 10: *Ending your membership in the plan*

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Aetna Medicare Plan (PPO) 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 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 cost share until your membership ends.

It is important that you carefully consider your decision to disenroll from our plan PRIOR to disenrolling. Since disenrollment from our plan could affect your former employer/union/trust health benefits, you could permanently lose your former employer/union/trust health coverage. If you are considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

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

Because you are enrolled in our plan through your former employer/union/trust, you are allowed to make plan changes at times permitted by your plan sponsor.

If your former employer/union/trust plan holds an annual Open Enrollment Period, you may be able to make a change to your health coverage at that time. Your plan benefits administrator will let you know when your Open Enrollment Period begins and ends, what plan choices are available to you, and the effective date of coverage.

All members have the opportunity to leave the plan during the Annual Enrollment Period (This happens every year from October 15 to December 7) and during the Medicare Advantage Open Enrollment Period (This happens every year from January 1 to March 31). In certain situations, you may also be eligible to leave the plan at other times of the year. Because of your special situation (enrollment through your former employer/union/trust's group retiree plan) you are eligible to end your membership at any time through a Special Enrollment Period.

Section 2.1 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 2024** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this.

- —or— you can contact your benefits administrator.

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

It is important that you carefully consider your decision to disenroll from our plan PRIOR to disenrolling. Since disenrollment from our plan could affect your former employer/union/trust health benefits, you could permanently lose your former employer/union/trust health coverage. If you are considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

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

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

- **Continue to use our network provider to receive medical care.**
- **Continue to use our network pharmacies 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 healthy coverage begins).

SECTION 5 Aetna Medicare Plan (PPO) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?
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Aetna Medicare Plan (PPO) 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 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 not 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 and you will lose prescription drug coverage.

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 Plan (PPO) 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, 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* 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 laws 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 www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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 Plan (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

In some situations, other parties should pay for your medical care before your Medicare Advantage health 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

Chapter 11 Legal notices

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 2024, 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 [Dow.AetnaMedicare.com](https://www.dow.aetna.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 Plan (PPO), 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product.

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 that begins when you (or other qualified parties on your behalf) have spent \$8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all services from both network (preferred) providers and out-of-network (non-preferred) providers.

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, if applicable.) 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 a number of 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 don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you 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.

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 your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your 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).

Chapter 12 Definitions of important words

“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 type of complaint does not involve coverage or payment disputes.

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) – Negotiate with insurers to provide services for insureds on a flat fee or retainer basis. They allow physicians to remain independent while still collaborating with other doctors to achieve best practices and negotiate with insurers as a group (see Chapter 1, Section 6).

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 \$5,030.

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.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See “Extra Help.”

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 (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 Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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.

Chapter 12 Definitions of important words

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 services and supports (LTSS) 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 as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly 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.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies (if included in your plan).

Chapter 12 Definitions of important words

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. Your PPO plan has an annual limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

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. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart (*Schedule of Cost Sharing*). Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are 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.

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include 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 Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you, or if you are a member of our plan through your former employer/union/trust group retiree plan.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing (if included in your plan) 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 may 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 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	KEPRO, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-319-8452, 216-447-9604, TTY: 1-855-843-4776, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: keproqio.com
Region 2: New Jersey, New York, Puerto Rico, Virgin Islands	Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-866-815-5440, TTY: 1-866-868-2289, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, Website: livantaqio.com/en
Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-396-4646, TTY: 1-888-985-2660, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, Website: livantaqio.com/en
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, 813-280-8256, TTY: 1-855-843-4776, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: keproqio.com
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-524-9900, TTY: 1-888-985-8775, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, Website: livantaqio.com/en
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	KEPRO, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-315-0636, 216-447-9604, TTY: 1-855-843-4776, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: keproqio.com
Region 7: Iowa, Kansas, Missouri, Nebraska	Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-755-5580, TTY: 1-888-985-9295, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, Website: livantaqio.com/en
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	KEPRO, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-317-0891, 813-280-8256, TTY: 1-855-843-4776, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 11:00 AM to 3:00 PM, Website: keproqio.com
Region 9: American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-877-588-1123, TTY: 1-855-887-6668, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday 11:00 AM to 3:00 PM, Website: livantaqio.com/en

	Quality Improvement Organizations (QIO)
Region 10: Alaska, Idaho, Oregon, Washington	KEPRO, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-305-6759, 813-280-8256, TTY: 1-855-843-4776, 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
AK	Alaska Dept. of Health Division of Public Assistance, Address: PO Box 110640, 350 Main Street, Room 304, Juneau, AK 99811-0640, Phone: 1-800-780-9972 (coverage or billing), 1-800-478-7778 (eligibility), TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx
AL	Alabama Medicaid Agency, Address: PO Box 5624, Montgomery, AL 36103, Phone: 1-800-362-1504, 334-242-5000, TTY: 1-800-253-0799, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: medicaid.alabama.gov/
AR	Arkansas Medicaid, Address: PO Box 1437, Slot S401, Little Rock, AR 72203-1437, Phone: 1-800-482-8988, 1-800-482-5431, TTY: 501-682-8933, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: humanservices.arkansas.gov/divisions-shared-services/medical-services/
AS	American Samoa Medicaid State Agency, Address: PO Box 998383, Pago Pago, AS 96799, Phone: 684-699-4777, 684-699-4778, TTY: 711, Hours: Monday–Friday 8:00 AM–5:00 PM, Website: medicaid.as.gov
AZ	Arizona Health Care Cost Containment System (AHCCCS), Address: 801 E. Jefferson Street, Phoenix, AZ 85034, Phone: 1-800-654-8713, 602-417-4000, TTY: 1-800-842-6520, Hours: Monday–Friday 7:00 AM to 9:00 PM, Saturday 8:00 AM to 6:00 PM, Website: azahcccs.gov/
CA	California Department of Health Services Medi-Cal, Address: PO Box 138008, Sacramento, CA 95813-8008, Phone: 1-800-541-5555, 916-636-1980, TTY: 1-866-784-2595, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhcs.ca.gov
CO	HealthFirst Colorado, Address: 1570 Grant Street, Denver, CO 80203-1818, Phone: 1-800-221-3943, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: healthfirstcolorado.com/
CT	HUSKY, Connecticut's Health Care for Children & Adults, Address: 55 Farmington Ave., Hartford, CT 06105-3724, Phone: 1-877-284-8759, TTY: 1-866-492-5276, Hours: Monday–Friday 8:30 AM to 6:00 PM, Website: portal.ct.gov/HUSKY/Welcome
DC	The Department of Health Care Finance – DHCF, Address: 441 4th Street NW, 900S, Washington, DC 20001, Phone: 202-442-5988, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, Website: dhcf.dc.gov/service/medicaid
DE	Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA), Address: DHSS Herman Holloway Campus, Lewis Building, 1901 N. DuPont Highway, New Castle, DE 19720, Phone: 1-866-843-7212, 302-571-4900, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhss.delaware.gov/dhss/dmma/medicaid.html

	State Medicaid Office
FL	Florida Agency for Health Care Administration, Division of Medicaid, Address: 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308, Phone: 1-877-711-3662, TDD: 1-866-467-4970, Hours: Monday–Thursday, 8:00 AM to 8:00 PM, Friday 8:00 AM to 7:00 PM, Website: flmedicaidmanagedcare.com/home
GA	Georgia Medicaid, Address: Division of Family and Children Services, Customer Contact Center, 2 Peachtree Street NW, 19th Floor, Atlanta, GA 30303, Phone: 1-877-423-4746, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.georgia.gov/
GU	Guam Medicaid Assistance Program, Address: Department of Public Health & Social Services, ITC Building, Suite 219, 590 S. Marine Corps Dr., Tamuning, GU 96913-3532, Phone: 735-7245/7274 (Central), 635-7429/7488 (Northern), 828-7542/8524 (Southern), TTY: 711, Hours: 9:00 AM to 4:00 PM, Website: dphss.guam.gov
HI	Hawaii Med-QUEST Division, Address: 1390 Miller Street, Suite 209, Honolulu, HI 96813-2403, Phone: 808-524-3370 (Oahu), 1-800-316-8005 (Neighbor Islands), TTY: 711, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: medquest.hawaii.gov/
IA	IA Health Link, Address: PO Box 36510, Des Moines, IA 50315, Phone: 1-800-338-8366, 515-256-4606, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.iowa.gov/IAHEALTHLINK
ID	Idaho Department of Health and Welfare, Address: PO Box 83720, Boise, ID 83720-0036, Phone: 1-877-456-1233, TTY: 1-888-791-3004, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: idalink.idaho.gov/
IL	Illinois Department of Healthcare and Family Services, Address: 201 S. Grand Ave. E, Springfield IL 62704, Phone: 1-800-843-6154, 1-866-468-7543, TTY: 1-800-447-6404, 1-877-204-1012, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: illinois.gov/hfs/Pages/default.aspx
IN	Indiana Medicaid, Address: 402 W. Washington Street, Room W392, PO Box 7083, Indianapolis, IN 46204, Phone: 1-800-403-0864, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/medicaid/
KS	KanCare Medicaid for Kansas, Address: PO Box 3599, Topeka, KS 66601, Phone: 1-800-792-4884, TTY: 1-800-766-3777, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kancare.ks.gov/
KY	Kentucky Cabinet for Health and Family Services, Department for Medicaid Services, Address: 275 E. Main St. 6W-A, Frankfort, KY 40621, Phone: 1-800-635-2570, 1-855-306-8959, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dms/Pages/default.aspx
LA	Louisiana Department of Health, Address: PO Box 629, Baton Rouge, LA 70821-0629, Phone: 1-888-342-6207, TTY: 1-800-220-5404, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ldh.la.gov/subhome/1
MA	MassHealth, Address: One Ashburton Place, Boston, MA 02108, Phone: 1-800-841-2900, TTY: 1-800-497-4648, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mass.gov/orgs/masshealth
MD	Maryland Medicaid, Address: Herbert R. O'Connor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, Phone: 1-877-463-3464, 1-855-642-8572, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: mmcp.health.maryland.gov/Pages/home.aspx

	State Medicaid Office
ME	Office of MaineCare Services, Address: Office for Family Independence, 114 Corn Shop Lane, Farmington, ME 04938, Phone: 1-855-797-4357, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: maine.gov/dhhs/ofi/programs-services/health-care-assistance
MI	Michigan Medicaid Program, Address: Capitol View Building, 201 Townsend Street, Lansing, MI 48913, Phone: 1-800-642-3195, 517-373-3740, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: michigan.gov/medicaid
MN	Minnesota Department of Human Services, Medical Assistance (MA), Address: PO Box 64993, St. Paul, MN 55164-0993, Phone: 1-800-657-3739, 651-431-2670, TTY: 1-800-627-3529, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
MO	MO HealthNet, Address: 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, Phone: 1-800-392-2161, 573-751-4815, TTY: 1-800-735-2466, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mydss.mo.gov/healthcare
MP	Northern Mariana Islands Medical Assistance for the Needy (MAN) Program, Address: Commonwealth Medicaid Agency, Government Building No. 1252, Capitol Hill Rd., Caller Box 1007 Saipan MP 96950, Phone: 670-664-4880/82/86/87/88 (Eligibility), 670-664-4883/84 (Claims), TTY: 711, Hours: Monday–Thursday 7:30 AM to 1:00 PM, Closed on Fridays and holidays, Website: http://medicaid.cnmi.mp/
MS	Mississippi Division of Medicaid, Address: MS Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201, Phone: 1-800-421-2408, 601-659-6050, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.ms.gov/
MT	Montana Medicaid and HMK Plus, Address: 111 North Sanders Street, Helena, MT 59601-4520, PO Box 4210, Helena, MT 59604-4210, Phone: 1-800-362-8312, 1-888-706-1535, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
NC	NC Medicaid, Division of Health Benefits, Address: 2501 Mail Service Center, Raleigh, NC 27699-2501, Phone: 1-888-245-0179, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.ncdhhs.gov/
ND	North Dakota Department of Human Services, Medical Services Division, Address: 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250, Phone: 1-800-755-2604, 701-328-7068, TTY: 1-800-366-6888, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.nd.gov/healthcare/medicaid
NE	Nebraska Department of Health and Human Services System, Address: 301 Centennial Mall South, Lincoln, NE 68508, Phone: 1-855-632-7633, 402-471-3121, TTY: 1-800-833-7352, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhs.ne.gov/Pages/General-Medicaid-Information.aspx
NH	New Hampshire Department of Health and Human Services, Address: Division of Medicaid Services, 129 Pleasant Street, Concord, NH 03301, Phone: 1-800-852-3345, ext. 4344, 603-271-4344, TTY: 1-800-735-2964, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhhs.nh.gov/programs-services/medicaid

	State Medicaid Office
NJ	NJ Department of Human Services, Division of Medical Assistance & Health Services, Address: NJ Department of Human Services, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, Phone: 1-800-701-0710, TTY: 1-800-701-0720, Hours: Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM, Website: state.nj.us/humanservices/dmahs/
NM	Centennial Care, Address: NM Human Services Department, PO Box 2348, Santa Fe, NM 87504, Phone: 1-800-283-4465, TTY: 1-855-227-5485, Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: hsd.state.nm.us/lookingforassistance/centennial-care-overview/
NV	Nevada Department of Health and Human Services, Address: Nevada Medicaid, Customer Service, PO Box 30042, Reno, NV 89520-3042, Phone: 1-877-638-3472, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.nv.gov
NY	The New York Department of Health, Address: New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, Phone: 1-800-541-2831, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.ny.gov/health_care/medicaid/
OH	Ohio Department of Medicaid, Address: 50 W. Town Street, Suite 400, Columbus, OH 43215, Phone: 1-800-324-8680, TTY: 711, Hours: Monday–Friday 7:00 AM to 8:00 PM, Saturday 8:00 AM to 4:00 PM, Website: medicaid.ohio.gov/
OK	SoonerCare, Address: Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, Phone: 1-800-987-7767, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oklahoma.gov/ohca.html
OR	Oregon Health Plan (OHP), Address: PO Box 14015, Salem, OR 97309, Phone: 1-800-273-0557, TTY: 711, Hours: Monday–Friday 7:00 AM to 6:00 PM, Website: oregon.gov/oha/hsd/ohp/Pages/index.aspx
PA	Pennsylvania Department of Human Services, Address: 625 Forster Street, Harrisburg, PA 17120, Phone: 1-800-692-7462, TTY: 1-800-451-5886, 711, Hours: Monday–Friday 8:30 AM to 4:45 PM, Website: dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
PR	Medicaid Program, Address: Department Of Health, P.O. Box 70184, San Juan, PR 00936-8184, Phone: 787-641-4224, TTY: 787-625-6955, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: medicaid.pr.gov
RI	Rhode Island Department of Human Services, Address: PO Box 8709, Cranston, RI 02920-8787, Phone: 1-855-697-4347, TTY: 711, Hours: Monday, Tuesday, Thursday, Friday 8:30 AM to 3:00 PM, except holidays, Website: eohhs.ri.gov/consumer/health-care
SC	South Carolina Healthy Connections Medicaid, Address: SCDHHS, PO Box 100101, Columbia, SC 29202, Phone: 1-888-549-0820, TTY: 1-888-842-3620, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: scdhhs.gov/
SD	South Dakota Medicaid, Address: 700 Governors Drive, Pierre, SD 57501, Phone: 1-800-597-1603, 605-773-3165, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dss.sd.gov/medicaid/
TN	TennCare, Address: 310 Great Circle Road, Nashville, TN 37243, Phone: 1-855-259-0701 (Applications), 1-800-342-3145 (General), TTY: 1-877-779-3103, Hours: Monday–Friday 7:00 AM to 6:00 PM, Website: tn.gov/tenncare
TX	Texas Health and Human Services Commission, Address: 4900 N. Lamar Boulevard, Austin, TX 78751-2316, Phone: 1-800-252-8263, TTY: 1-800-735-2989, 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/medicaid-chip

	State Medicaid Office
UT	Utah Department of Health Medicaid, Address: PO Box 143106, Salt Lake City, UT 84114-3106, Phone: 1-800-662-9651, 801-538-6155 (Customer Service); 801-526-0950, 1-866-435-7414 (Eligibility), TTY: 711, Hours: Monday, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM and Thursday 11:00 AM to 5:00 PM, Website: medicaid.utah.gov/
VA	Cardinal Care Virginia Medicaid, Address: 600 E. Broad Street, Suite 1300, Richmond, VA 23219, Phone: 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), TTY: 1-888-221-1590, Hours: Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, Website: dmas.virginia.gov/
VI	Virgin Islands Medicaid Program, Address: Department of Human Services, Knud Hansen Complex 1303 Hospital Ground Bldg. A, St. Thomas, VI 00802; 3011 Golden Rock, Christiansted, St. Croix, VI 00820, Phone: 340-715-6929 (Customer Support), 340-774-0930 (St. Thomas/St. John), 340-772-7100 (St. Croix), TTY: 711, Hours: Monday–Friday 7:00 AM to 7:00 PM, Website: vimmis.com/default.aspx
VT	Vermont Medicaid Programs, Address: Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250-8427, 1-855-899-9600, TTY: 711, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: dvha.vermont.gov/members
WA	Washington Apple Health, Address: Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501, Phone: 1-800-562-3022, TTY: 711, Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: hca.wa.gov/
WI	Wisconsin Department of Health Services, Address: Division of Medicaid Services, PO Box 309, Madison, WI 53707-0309, Phone: 1-800-362-3002, 608-266-1865, TTY: 1-800-947-3529, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhs.wisconsin.gov/medicaid/index.htm
WV	West Virginia Department of Health & Human Resources, Bureau for Medical Services, Address: One Davis Square, Suite 100 East, Charleston, WV 25301, Phone: 1-877-716-1212, 304-558-1700, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhr.wv.gov/Pages/default.aspx
WY	Wyoming Department of Health, Healthcare Financing Division, Address: Customer Service Center, 3001 E. Pershing Blvd., Suite 125, Cheyenne, WY 82001, Phone: 1-855-294-2127, 307-777-7531, TTY: 1-855-329-5204, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.wyo.gov/

	State Health Insurance Assistance Program (SHIP)
AK	Alaska State Health Insurance Counseling and Assistance Programs, Address: 1835 Bragaw Street, Suite 350, Anchorage, AK 99508, Phone: 1-800-478-6065, 907-269-3680, TTY: 1-800-770-8973, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhss.alaska.gov/dsds/Pages/medicare/ship.aspx
AL	Alabama State Health Insurance Assistance Program, Address: 201 Monroe Street, RSA Tower, Suite 350, Montgomery, AL 36130-1851, Phone: 1-800-243-5463, 1-877-425-2243, 334-242-5743, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: alabamaageline.gov/ship/
AR	Arkansas Senior Health Insurance Information Program (AR SHIP), Address: 1 Commerce Way, Little Rock, AR 72202, Phone: 1-800-224-6330, 501-372-2782, TTY: 501-683-4468, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: shiipar.com

	State Health Insurance Assistance Program (SHIP)
AZ	Arizona State Health Insurance Assistance Program, Address: 1789 W. Jefferson Street, Mail Drop 6288, Phoenix, AZ 85007, Phone: 1-800-432-4040, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: des.az.gov/services/older-adults/medicare-assistance
CA	California Health Insurance Counseling and Advocacy Program (HICAP), Address: 2880 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, Phone: 1-800-434-0222, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.ca.gov/hicap/
CO	Colorado Senior Health Insurance Assistance Program (SHIP), Address: 1560 Broadway, Suite 850, Denver, CO 80202, Phone: 1-888-696-7213, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare
CT	CHOICES, Address: 55 Farmington Ave., 12th Floor, Hartford, CT 06105, Phone: 1-800-994-9422, TTY: 860-247-0775, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: portal.ct.gov/ADS-CHOICES
DC	Health Insurance Counseling Project (HICP), Address: 500 K Street NE, Washington, DC 20002, Phone: 202-727-8370, TTY: 711, Hours: Monday–Friday 9:30 AM to 4:30 PM, Website: dacl.dc.gov/service/health-insurance-counseling
DE	Delaware Medicare Assistance Bureau (DMAB), Address: 1351 W. North Street, Suite 101, Dover, DE 19904, Phone: 1-800-336-9500, 302-674-7364, TTY: 711, Hours: Monday–Friday 8:30 AM to 3:30 PM, Website: delawareinsurance.gov/DMAB/
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/
GA	Georgia SHIP, Address: 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303, Phone: 1-866-552-4464, Option 4, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.georgia.gov/georgia-ship
GU	Guam SHIP, Address: Department of Public Health and Social Services, Division of Senior Citizens, Guam Department of Public Health and Social Services, 123 Chalan Kareta, Mangilao, Guam 96913-6304, Phone: 671-735-7415, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphss.guam.gov
HI	Hawaii SHIP, Address: Executive Office on Aging, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, Phone: 1-888-875-9229, 808-586-7299, TTY: 1-866-810-4379, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: hawaiiiship.org/
IA	Iowa Senior Health Insurance Information Program (SHIIP), Address: 1963 Bell Ave., Suite 100, Des Moines, IA 50315, Phone: 1-800-351-4664, TTY: 1-800-735-2942, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: shiip.iowa.gov/
ID	Idaho Senior Health Insurance Benefits Advisors (SHIBA), Address: 700 W. State Street, 3rd Floor, PO Box 83720, Boise, ID 83720-0043, Phone: 1-800-247-4422, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: doi.idaho.gov/SHIBA/
IL	Senior Health Insurance Program (SHIP), Address: One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, Phone: 1-800-252-8966, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: www2.illinois.gov/aging/ship/Pages/default.aspx
IN	Indiana State Health Insurance Assistance Program, Address: 311 W. Washington Street, Suite 300, Indianapolis, IN 46204-2787, Phone: 1-800-452-4800, TTY: 1-866-846-0139,

	State Health Insurance Assistance Program (SHIP)
	Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/ship/
KS	Senior Health Insurance Counseling for Kansas (SHICK), Address: New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, Phone: 1-800-860-5260, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick
KY	Kentucky State Health Insurance Assistance Program, Address: 275 E. Main Street, Suite 3E-E, Frankfort, KY 40621, Phone: 1-877-293-7447 (Option 2), 502-564-6930, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dail/Pages/ship.aspx
LA	Louisiana Senior Health Insurance Information Program (SHIIP), Address: 1702 N. Third Street, PO Box 94214, Baton Rouge, LA 70802, Phone: 1-800-259-5300, Option 2, 225-342-5301, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: ldi.la.gov/consumers/senior-health-shiip
MA	SHINE (Serving Health Insurance Needs of Everyone), Address: 1 Ashburton Place, 5th Floor, Boston, MA 02108, Phone: 1-800-243-4636, TTY/ASCII: TTY/ASCII: 1-800-439-2370, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: mass.gov/health-insurance-counseling
MD	Maryland State Health Insurance Assistance Program, Address: 301 West Preston Street, Suite 1007, Baltimore, MD 21201, Phone: 1-800-243-3425, 410-767-1100, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.maryland.gov/Pages/state-health-insurance-program.aspx
ME	Maine State Health Insurance Assistance Program, Address: 109 Capitol Street, 11 State House Station, Augusta, ME 04333, Phone: 1-800-262-2232, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
MI	Michigan Medicare/Medicaid Assistance Program (MMAP, INC.), Address: 6105 W. St. Joseph, Suite 204, Lansing, MI 48917, Phone: 1-800-803-7174, TTY: 1-888-263-5897, Hours: Monday–Friday 8:00 AM to 7:00 PM, Website: mmapinc.org/
MN	Minnesota State Health Insurance Assistance Program (SHIP), Address: 540 Cedar Street, PO Box 64976, St. Paul, MN 55164, Phone: 1-800-333-2433, TTY: 1-800-627-3529, Hours: Monday–Friday 8:00AM to 4:30 PM, Website: mn.gov/senior-linkage-line/
MO	Missouri SHIP, Address: 601 W. Nifong Blvd. Suite 3A, Columbia, MO 65203, Phone: 1-800-390-3330, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: missouriship.org
MS	Mississippi State Health Insurance Assistance Program (SHIP), Address: 200 South Lamar St., Jackson, MS 39201, Phone: 1-800-948-3090, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/
MT	Montana State Health Insurance Assistance Program (SHIP), Address: PO Box 4210, Helena, MT 59604, Phone: 1-800-551-3191, TTY: 1-800-833-8503, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/sltc/aging/ship
NC	Seniors' Health Insurance Information Program (SHIIP), Address: Albemarle Building, 325 N. Salisbury Street, Raleigh, NC 27603, Phone: 1-855-408-1212, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip

	State Health Insurance Assistance Program (SHIP)
ND	State Health Insurance Counseling Program (SHIC), Address: 600 E. Boulevard Ave., Bismarck, ND 58505-0320, Phone: 1-888-575-6611, TTY: 1-800-366-6888, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.nd.gov/shic-medicare
NE	Nebraska SHIP, Address: 2717 S. 8th Street, Suite 4, Lincoln, NE 68502, Phone: 1-800-234-7119, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: doi.nebraska.gov/consumer/senior-health
NH	New Hampshire State Health Insurance Assistance Program (SHIP), Address: 129 Pleasant Street, Concord, NH 03301, Phone: 1-866-634-9412, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: servicelink.nh.gov/medicare/index.htm
NJ	State Health Insurance Assistance Program (SHIP), Address: State Health Insurance Assistance Program, PO Box 807, Trenton, NJ 08625, Phone: 1-800-792-8820, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: state.nj.us/humanservices/doas/services/ship
NM	New Mexico State Health Insurance Assistance Program (SHIP), Address: 2550 Cerrillos Road, Santa Fe, NM 87505, Phone: 1-800-432-2080, 505-476-4846, TTY: 505-476-4937, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: aging.nm.gov
NV	Nevada State Health Insurance Assistance Program (SHIP), Address: 3416 Goni Road, Suite D-132, Carson City, NV 89706, Phone: 1-800-307-4444, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
NY	Health Insurance Information, Counseling and Assistance (HIICAP), Address: 2 Empire State Plaza, 5th Floor, Albany, NY 12223, Phone: 1-800-701-0501, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.ny.gov/health-insurance-information-counseling-and-assistance
OH	Ohio Senior Health Insurance Information Program (OSHIIP), Address: 50 W. Town Street, Third Floor, Suite 300, Columbus, OH 43215, Phone: 1-800-686-1578, 614-644-2658, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.ohio.gov
OK	Oklahoma Senior Health Insurance Counseling Program (SHIP), Address: 400 NE 50th Street, Oklahoma City, OK 73105, Phone: 1-800-763-2828, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oid.ok.gov/consumers/information-for-seniors/
OR	Oregon Senior Health Insurance Benefits Assistance (SHIBA), Address: 350 Winter Street NE, Salem, OR 97309-0405, Phone: 1-800-722-4134, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: shiba.oregon.gov/
PA	Pennsylvania Medicare Education and Decision Insight (PA MEDI), Address: 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, Phone: 1-800-783-7067, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx
PR	Programa Estatal de Asistencia Sobre Seguros de Salud (SHIP: State Health Insurance Assistance Program), Address: Oficina del Procurador de las Personas de Edad Avanzada, Oficina Central, Avenida Ponce de León, Parada 16 Edificio 1064 tercer piso, Santurce (altos del edificio de Marshalls), San Juan, PR 00919-1179, Phone: 1-800-981-0056 (Mayaguez); 1-800-981-7735 (Ponce); 1-877-725-4300 (Saint John), TTY: 787-919-7291, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx

	State Health Insurance Assistance Program (SHIP)
RI	State Health Insurance Assistance Program (SHIP), Address: 25 Howard Ave., Building 57, Cranston, RI 02920, Phone: 1-888-884-8721, TTY: 401-462-0740, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oha.ri.gov/Medicare
SC	State Health Insurance Assistance Program (SHIP), Address: 1301 Gervais Street, Suite 350, Columbia, SC 29201, Phone: 1-800-868-9095, TTY: 1-888-842-3620, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: getcaresc.com/guide/insurance-counseling-medicaremedicaid
SD	Senior Health Information and Insurance Education (SHIINE), Address: 700 Governors Drive, Pierre, SD 57501-2291, Phone: 1-800-536-8197 (Eastern SD), 1-877-331-4834 (Central SD), 1-877-286-9072 (Western SD), TTY: 711, Hours: Monday–Friday 9:00 AM to 4:30 PM, Website: shiine.net/
TN	Tennessee SHIP (State Health Insurance Assistance Program), Address: Andrew Jackson Bldg., 9th Floor, 502 Deaderick Street, Nashville, TN 37243, Phone: 1-877-801-0044, TTY: 1-800-848-0299, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: tnmedicarehelp.com/
TX	Texas Health Information, Counseling and Advocacy Program (HICAP), Address: 701 W. 51st Street, MC: W275, Austin, TX 78751, Phone: 1-800-252-9240, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/medicare
UT	Utah Senior Health Insurance Information Program (SHIP), Address: 195 N. 1950 West, Salt Lake City, UT 84116, Phone: 1-800-541-7735, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: daas.utah.gov/seniors/
VA	Virginia Insurance Counseling and Assistance Program (VICAP), Address: 1610 Forest Ave., Suite 100, Henrico, VA 23229, Phone: 1-800-552-3402, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: vda.virginia.gov/vicap.htm
VI	Virgin Islands State Health Insurance Assistance Program (VISHIP), Address: Commissioner of Banking & Insurance, 4007 Estate Diamond Ruby - 1st Floor, Christiansted, VI 00820, Phone: 340-772-7368, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: ltg.gov.vi/departments/vi-ship-medicare/
VT	Vermont State Health Insurance Assistance Program (SHIP), Address: 476 Main Street, Suite 3, Winooski, VT 05404, Phone: 1-800-642-5119, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: vermont4a.org/medicare-information
WA	Washington Statewide Health Insurance Benefits Advisors (SHIBA), Address: Office of the Insurance Commissioner, 5000 Capitol Blvd., Tumwater, WA 98504-0256, Phone: 1-800-562-6900, TTY: 360-586-0241, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba
WI	Wisconsin State Health Insurance Assistance Program (SHIP), Address: 1 W. Wilson Street, Madison, WI 53703, Phone: 1-800-242-1060, TTY: 1-800-947-3529, 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
WV	West Virginia State Health Insurance Assistance Program (WV SHIP), Address: 1900 Kanawha Blvd. East, (3rd Floor Town Center Mall) Charleston, WV 25305-0160, Phone: 1-877-987-4463, 304-558-3317, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: wvship.org
WY	Wyoming State Health Insurance Information Program (WSHIP), Address: 106 W. Adams Ave., Riverton, WY 82501, Phone: 1-800-856-4398, TTY: 711, Hours: Monday–Friday 7:00 AM

	State Health Insurance Assistance Program (SHIP)
	to 4:00 PM, Website: wyomingseniors.com/

	State Pharmaceutical Assistance Program (SPAP)
DE	Delaware Prescription Assistance Program, Address: DXC DPAP, PO Box 950, New Castle, DE 19720-0950, Phone: 1-844-245-9580, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhss.delaware.gov/dhss/dmma/dpap.html
DE	Delaware Chronic Renal Disease Program, Address: 253 NE Front Street, Milford, DE 19963, Phone: 302-424-7180, 1-800-464-4357, TTY: 711, Website: dhss.delaware.gov/dhss/dmma/crdprog.html
IN	HoosierRx, Address: 402 W. Washington, Room 372, Indianapolis, IN 46204, Phone: 1-866-267-4679, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: in.gov/medicaid/members/member-programs/hoosierx/
MA	Prescription Advantage, Address: PO Box 15153, Worcester, MA 01615-0153, Phone: 1-800-243-4636, TTY: 1-877-610-0241, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: mass.gov/prescription-drug-assistance
MD	Maryland Senior Prescription Drug Assistance Program (SPDAP), Address: Maryland – SPDAP c/o International Software Systems Inc., PO Box 749, Greenbelt, Maryland 20768-0749, Phone: 1-800-551-5995, TTY: 1-800-877-5156, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: marylandspdap.com/
ME	Maine Low Cost Drugs for the Elderly or Disabled Program, Address: Office of Family Independence, State of Maine - DHHS, 114 Corn Shop Lane, Farmington, ME 04938, Phone: 1-855-797-4357, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: apps1.web.maine.gov/benefits/account/login.html
MO	Missouri Rx Plan (MORx), Address: PO Box 2700, Jefferson City, MO 65102, Phone: 1-800-375-1406, 573-751-6963, TTY: 1-800-735-2966, Hours: Monday–Friday 6:00 AM to 6:00 PM, Website: dss.mo.gov/mhd/faq/pages/faqmo_rx.htm
MT	Montana Big Sky Rx Program, Address: PO Box 202915, Helena, MT 59620-2915, Phone: 1-866-369-1233, 406-444-1233, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
NJ	New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD), Address: PAAD-HAAAD, Department of Human Services, PO Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-9745, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: state.nj.us/humanservices/doas/services/paad/
NJ	New Jersey Senior Gold Prescription Discount Program, Address: Division of Aging Services, PO Box 715, Trenton, NJ 08625-0715, Phone: 1-800-792-9745, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: state.nj.us/humanservices/doas/services/seniorgold/
NM	New Mexico Medical Insurance Pool (NMMIP), Address: 1223 St. Francis Drive, Suite B, Santa Fe, NM 87505, Phone: 1-844-728-7896, 620-793-1121, TTY: 1-844-728-7987, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: nmmip.org
NV	Nevada Disability Rx Program, Address: ADSD, Attn: SRx/DRx, 3208 Goni Road, Building I,

	State Pharmaceutical Assistance Program (SPAP)
	Suite 181, Carson City, NV 89706, Phone: 1-866-303-6323, Option 2, 775-687-4210, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: adsd.nv.gov/Programs/Physical/DisabilityRx/DisabilityRx/
NV	Nevada Senior Rx Program, Address: ADSD, Attn: SRx/DRx, 3208 Goni Road, Building I, Suite 181, Carson City, NV 89706, Phone: 1-866-303-6323, Option 2, 775-687-4210, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/
NY	Elderly Pharmaceutical Insurance Coverage (EPIC) Program, Address: EPIC, PO Box 15018, Albany, NY 12212-5108, Phone: 1-800-332-3742, TTY: 1-800-290-9138, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.ny.gov/health_care/epic/
PA	PACE/PACENET Prescription Assistance Program, Address: Pennsylvania Department of Aging, PO Box 8806, Harrisburg, PA 17105-8806, Phone: 1-800-225-7223, 717-787-7313, TTY: 1-800-222-9004, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
PA	Special Pharmaceutical Benefits Program - Mental Health, Address: Department of Human Services - OMHSAS, Business Partner Support Unit - SPBP-MH Program, Commonwealth Tower, 12th Floor, PO Box 2675, Harrisburg, PA 17105-2675, Phone: 1-877-356-5355, Option 2, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Special-Pharm-Benefits-Program.aspx
PA	Chronic Renal Disease Program (CRDP), Address: The Chronic Renal Disease Program, Pennsylvania Department of Health, Division of Child and Adult Health Services, 625 Forster St., 7th Floor East Wing, Harrisburg, PA 17120-0701, Phone: 1-800-225-7223, 717-787-7313, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: health.pa.gov/topics/programs/Chronic-Renal-Disease
RI	RI Pharmaceutical Assistance to Elders (RIPAE), Address: RI Office of Health Aging, 25 Howard Avenue Louis Pasteur Bldg., #57 Cranston, RI 02920, Phone: 401-462-3000, 401-462-0560, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance
TX	Kidney Health Care Program (KHC), Address: Kidney Health Care, MC 1938, PO Box 149030, Austin, TX 78714-9947, Phone: 1-800-222-3986, Option 2, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/kidney-health-care
VT	VPharm and Healthy Vermonters Programs, Address: Green Mountain Care, Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250-8427, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:00 PM, Website: dvha.vermont.gov/members/prescription-assistance
WI	SeniorCare, Address: Senior Care, PO Box 6710, Madison, WI 53716-0710, Phone: 1-800-657-2038, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhs.wisconsin.gov/seniorcare/index.htm

	State AIDS Drug Assistance Programs (ADAP)
AK	Alaska AIDS Drug Assistance Program (ADAP), Address: Anchorage – 1057 W. Fireweed Lane, Suite 102, Anchorage, AK 99503 Juneau – 225 Front Street, Suite 103-A, Juneau, AK

	State AIDS Drug Assistance Programs (ADAP)
	99801, Phone: 1-800-478-AIDS (2437), Anchorage: 907-263-2050, Juneau: 907-500-7465, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: alaskan aids.org/client-services/aids-drug-assistance-program-adap
AL	Alabama AIDS Drug Assistance Program (ADAP), Address: Office of HIV Prevention and Care, Alabama Department of Public Health, The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104, Phone: 1-866-574-9964, TTY: 711, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: alabamapublichealth.gov/hiv/adap.html
AR	Ryan White Program, Arkansas AIDS Drug Assistance Program (ADAP), Address: 4815 W. Markham, Little Rock, AR 72205, Phone: 1-800-462-0599, Option 3, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: healthy.arkansas.gov/programs-services/topics/ryan-white-program
AZ	Arizona AIDS Drug Assistance Program (ADAP), Address: Arizona Department of Health Services, 150 N. 18th Ave., Suite 280, Phoenix, AZ 85007, Phone: 1-800-334-1540, 602-364-3610, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home
CA	California AIDS Drug Assistance Program (ADAP), Address: PO Box 997377, MS 0500, Sacramento, CA 95899-7377, Phone: 1-844-421-7050, 916-558-1784, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: cdph.ca.gov/Programs/CID/DOA/pages/oaadap.aspx
CO	Colorado State Drug Assistance Program (SDAP), Address: 4300 Cherry Creek Drive South, Denver, CO 80246, Phone: 303-692-2716, TTY: 711, Hours: Monday–Friday 7:30 AM to 5:15 PM, Website: cdphe.colorado.gov/state-drug-assistance-program
CT	Connecticut AIDS Drug Assistance Program (CADAP), Address: State of CT Department of Public Health c/o Magellan Rx Management, PO Box 13001, Albany, NY 12212-3001, Phone: 1-800-424-3310, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: ctdph.magellanrx.com/
DC	DC AIDS Drug Assistance Program (ADAP), Address: 899 North Capitol Street NE, Washington, DC 20002, Phone: 202-671-4815, TTY: 711, Hours: Monday–Friday 8:15 AM to 4:45 PM, except district holidays, Website: dchealth.dc.gov/DC-ADAP
DE	Delaware AIDS Drug Assistance Program (ADAP), Address: Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901, Phone: 302-744-1050, Option 1, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhss.delaware.gov/dph/dpc/hivtreatment.html
FL	Florida AIDS Drug Assistance Program (ADAP), Address: HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, Phone: 1-800-352-2437, 844-381-2327, TTY: 1-888-503-7118, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: floridahealth.gov/diseases-and-conditions/aids/adap/
GA	Georgia AIDS Drug Assistance Program (ADAP), Address: 200 Piedmont Avenue, SE, Atlanta, GA 30334, Phone: 404-656-9805, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dph.georgia.gov/health-topics/office-hiv-aids/hiv-care/aids-drug-assistance-program-adap
HI	Hawaii HIV Drug Assistance Program (HDAP), Address: 3627 Kilauea Ave., Suite 306, Honolulu, HI 96816, Phone: 808-733-9360, TTY: 711, Hours: Monday–Friday 7:45 AM to 2:30 PM, Website: health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-

	State AIDS Drug Assistance Programs (ADAP)
	management-services/
IA	Iowa AIDS Drug Assistance Program (ADAP), Address: Lucas State Office Building, 321 E. 12th Street, Des Moines, IA 50319-0075, Phone: 515-204-3746, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: idph.iowa.gov/hivstdhep/hiv/support
ID	Idaho AIDS Drug Assistance Program (ADAP), Address: 450 W. State Street, PO Box 83720, Boise, ID 83720-0036, Phone: 208-334-5612, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv
IL	Illinois AIDS Drug Assistance Program (ADAP), Address: 525 W. Jefferson Street, 1st Floor, Springfield, IL 62761, Phone: 1-800-825-3518, TTY: 711, Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services
IN	Indiana AIDS Drug Assistance Program (ADAP), Address: 2 N. Meridian Street, Suite C, Indianapolis, IN 46204, Phone: 1-866-588-4948, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: in.gov/health/hiv-std-viral-hepatitis/hiv-services/
KS	The Ryan White Part B Program, Address: Curtis State Office Building, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, Phone: 785-296-6174, Option 5, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kdhe.ks.gov/355/The-Ryan-White-Part-B-Program
KY	Kentucky AIDS Drug Assistance Program (KADAP), Address: 275 E. Main Street, HS2E-C, Frankfort, KY 40621, Phone: 1-800-420-7431, 502-564-6539, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dph/dehp/hab/pages/services.aspx
LA	Louisiana Health Access Program (LA HAP), Address: 1450 Poydras Street, Suite 2136, New Orleans, LA 70112, Phone: 504-568-7474, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: lahap.org/
MA	Massachusetts HIV/AIDS Drug Assistance Program (HDAP), Address: AccessHealth MA, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129, Phone: 1-800-228-2714, 617-502-1700, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: accesshealthma.org/drug-assistance/hdap/
MD	Maryland AIDS Drug Assistance Program (MADAP), Address: 1223 W. Pratt Street, Baltimore, MD 21223, Phone: 1-800-205-6308, 410-767-6535, TTY: 1-800-735-2258, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
ME	Maine AIDS Drug Assistance Program (ADAP), Address: Maine Ryan White Program, 40 State House Station, Augusta, ME 04330, Phone: 207-287-3747, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml
MI	Michigan HIV/AIDS Drug Assistance Program (MIDAP), Address: Michigan Drug Assistance Program, HIV Care Section, Division of HIV/STI Programs, Client, and Partner Services, Bureau of HIV and STI Programs, Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909, Phone: 1-888-826-6565, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: michigan.gov/dap
MN	Minnesota Aids Drug Assistance Program (Program HH), Address: Minnesota Department of Human Services, Program HH, PO Box 64972, St. Paul, MN 55164-0972, Phone: 1-800-657-3761, 651-431-2414, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM,

	State AIDS Drug Assistance Programs (ADAP)
	Website: rainbowhealth.org/living-with-hiv/assistance/health-insurance/program-hh/
MO	Missouri HIV/AIDS Case Management Program, Address: Bureau of HIV, STD, and Hepatitis, Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102, Phone: 573-751-6439, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
MS	Mississippi AIDS Drug Assistance Program (ADAP), Address: Office of STD/HIV Care and Treatment Division, PO Box 1700, Jackson, MS 39215, Phone: 1-888-343-7373, 601-362-4879, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: msdh.ms.gov/msdhsite/_static/14,13047,150.html
MT	Montana AIDS Drug Assistance Program (ADAP), Address: Cogswell Building, Room C-211, 1400 Broadway, Helena, MT 59620, Phone: 406-444-3565, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
NC	North Carolina HIV Medication Assistance Program (NC HMAP), Address: NC Department of Health and Human Services Division of Public Health, Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh, NC 27699-1907, Phone: 1-877-466-2232, 919-733-9161, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: epi.dph.ncdhhs.gov/cd/hiv/hmap.html
ND	North Dakota AIDS Drug Assistance Program (ADAP), Address: North Dakota Department of Health, Division of Disease Control, 2635 E. Main Avenue, PO Box 5520, Bismarck, ND 58505, Phone: 1-800-472-2180, 701-328-2378, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ndhealth.gov/hiv/
NE	Nebraska Ryan White AIDS Drug Assistance Program (ADAP), Address: Nebraska Department of Health & Human Services, PO Box 95026, Lincoln, NE 68509-5026, Phone: 402-471-2101, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhs.ne.gov/Pages/HIV-Care.aspx
NH	New Hampshire Ryan White CARE Program, Address: 29 Hazen Drive, Concord, NH 03301, Phone: 1-800-852-3345 ext. 4502, 603-271-4502, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program
NJ	New Jersey AIDS Drug Distribution Program (ADDP), Address: PO Box 722, Trenton, NJ 08625-0722, Phone: 1-877-613-4533, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: nj.gov/health/hivstdtb/hiv-aids/medications.shtml
NM	New Mexico AIDS Drug Assistance Program (ADAP), Address: Infectious Disease Bureau, Public Health Division, 1190 S. St. Francis Drive, Room S-1204, Santa Fe, NM 87505, Phone: 505-709-7618, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: nmhealth.org/about/phd/idb/hats/
NV	Nevada AIDS Drug Assistance Program (ADAP)/NV Medication Assistance Program, Address: 2290 S. Jones Blvd., Suite 110, Las Vegas, Nevada 89146, Phone: 702-486-0768, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: endhivnevada.org
NY	New York AIDS Drug Assistance Program (ADAP), Address: HIV Uninsured Care Programs, Empire Station, PO Box 2052, Albany, NY 12220-0052, Phone: 1-800-542-2437, 1-844-682-4058, 518-459-1641, TTY: 518-459-0121, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.ny.gov/diseases/aids/general/resources/adap/

	State AIDS Drug Assistance Programs (ADAP)
OH	Ohio HIV Drug Assistance Program (OHDAP), Address: Ohio Department of Health, 246 N. High Street, Columbus, OH 43215, Phone: 1-800-777-4775, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
OK	Oklahoma AIDS Drug Assistance Program (ADAP), Address: Oklahoma State Department of Health, Sexual Health and Harm Reduction Services, 123 Robert S. Kerr Avenue, Suite 1702, Oklahoma City, OK 73102-6406, Phone: 405-426-8400, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oklahoma.gov/health/services/personal-health/sexual-health-and-harm-reduction-service/community-resources---partners.html
OR	Oregon CAREAssist, Address: 800 NE Oregon Street, Suite 1105, Portland, OR 97232, Phone: 971-673-0144, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oregon.gov/oha/PH/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
PA	Pennsylvania Special Pharmaceutical Benefits Program – HIV/AIDS, Address: Department of Health Special Pharmaceutical Benefits Program, PO Box 8808, Harrisburg, PA 17105-8808, Phone: 1-800-922-9384, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
RI	Rhode Island AIDS Drug Assistance Program (ADAP), Address: Executive Office of Health & Human Services, Virks Building, 3 West Rd., Suite 227, Cranston, RI 02920, Phone: 401-462-3294, 401-462-3295, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx
SC	South Carolina AIDS Drug Assistance Program (ADAP), Address: SC Drug Assistance Program/Insurance Assistance Program, 3rd Floor, Mills/Jarrett Box 101106, Columbia, SC 29211, Phone: 1-800-856-9954, TTY: 711, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: scdhec.gov/aids-drug-assistance-program
SD	South Dakota AIDS Drug Assistance Program (ADAP), Address: Ryan White Part B CARE Program, South Dakota Department of Health, 615 E. 4th Street, Pierre, SD 57501-1700, Phone: 1-800-592-1861, 605-773-3737, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: doh.sd.gov/topics/diseases-conditions/communicable-infectious-diseases/reportable-communicable-diseases/hiv aids/ryan-white-part-b-program/
TN	Tennessee AIDS Drug Assistance Program (ADAP), Address: TN Department of Health, HIV/STD Program, Ryan White Part B Services, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243, Phone: 1-800-525-2437, 615-741-7500, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
TX	Texas HIV Medication Program (THMP), Address: ATTN: MSJA, MC 1873, PO Box 149347, Austin, TX 78714-9347, Phone: 1-800-255-1090, 737-255-4300, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dshs.state.tx.us/hivstd/meds/default.shtm
UT	Utah Ryan White Part B ADAP AIDS Drug Assistance Program, Address: Utah Department of Health, Bureau of Epidemiology, 288 N 1460 West, PO Box 142104, Salt Lake City, UT 84114-2104, Phone: 801-538-6197, 801-538-6191, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ptc.health.utah.gov/treatment/ryan-white/
VA	Virginia Medication Assistance Program (VA MAP), Address: Department of Health, 109 Governor Street, Richmond, VA 23219, Phone: 1-855-362-0658, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: vdh.virginia.gov/disease-prevention/vamap/

	State AIDS Drug Assistance Programs (ADAP)
VT	Vermont Medication Assistance Program (VMAP), Address: 108 Cherry Street, PO Box 70, Burlington, VT 05402-0070, Phone: 802-951-4005, 1-800-464-4343 ext. 4005, TTY: 711, Hours: Monday–Friday 7:45 AM to 3:30 PM, Website: healthvermont.gov/immunizations-infectious-disease/hiv/care
WA	Washington Early Intervention Program (EIP), Address: Client Services, PO Box 47841, Olympia, WA 98504, Phone: 1-877-376-9316, 360-236-3426, TTY: 711, Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP
WI	Wisconsin AIDS/HIV Drug Assistance Program (ADAP), Address: Division of Public Health, Attn: ADAP, PO Box 2659, Madison, WI 53701, Phone: 1-800-991-5532, 608-261-6952, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhs.wisconsin.gov/hiv/adap.htm
WV	West Virginia AIDS Drug Assistance Program (ADAP), Address: Jay Adams, HIV Care Coordinator, PO Box 6360, Wheeling, WV 26003, Phone: 304-232-6822, TTY: 711, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: oeps.wv.gov/rwp/pages/default.aspx
WY	Wyoming AIDS Drug Assistance Program (ADAP), Address: Wyoming Department of Health, 122 W. 25th Street, 3rd Floor West, Cheyenne, WY 82002, Phone: 307-777-5856, TTY: 711, Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: health.wyo.gov/publichealth/communicable-disease-unit/hiv/resources-for-patients/

Addendum B

Aetna Medicare Plan (PPO ESA) Service Areas

Your Aetna Medicare Plan (PPO ESA) is available in all counties within the 50 states, Washington D.C., and the Territories of American Samoa, Northern Mariana Islands, Guam, Puerto Rico and U.S. Virgin Islands.

Below is a list of our network-based service areas. Your plan sponsor may not offer coverage in each of these counties. If you are moving to a new service area, you should contact your former employer to ask what coverage options may be available to you. to ask what coverage options may be available to you.

Addendum B: Aetna PPO ESA

Alabama
Barbour • Chambers • Dale • Henry • Houston • Macon • Mobile • Russell
Arizona
Graham • La Paz • Maricopa • Mohave • Pima • Pinal • Santa Cruz • Yavapai • Yuma
California
Fresno • Los Angeles • Orange • Riverside • San Bernardino • San Diego • San Francisco • Ventura
Colorado
Adams • Arapahoe • Boulder • Broomfield • Denver • Douglas • El Paso • Jefferson • Larimer • Weld
Connecticut
Fairfield • Hartford • Litchfield • Middlesex • New Haven • New London • Tolland • Windham
Delaware
Kent • New Castle • Sussex
District of Columbia
Washington DC
Florida
Bradford • Brevard • Broward • Charlotte • Citrus • Clay • Collier • DeSoto • Duval • Flagler • Hernando • Highlands • Hillsborough • Indian River • Lake • Lee • Manatee • Marion • Martin • Miami-Dade • Nassau • Orange • Osceola • Palm Beach • Pasco • Pinellas • Polk • Sarasota • Seminole • St. Johns • St. Lucie • Volusia
Georgia
Appling • Baldwin • Banks • Barrow • Bartow • Ben Hill • Bibb • Bleckley • Bryan • Burke • Butts • Camden • Carroll • Catoosa • Charlton • Chatham • Chattahoochee • Cherokee • Clarke • Clayton • Clinch • Cobb • Coffee • Columbia • Coweta • Crawford • Crisp • Dawson • DeKalb • Dooly • Dougherty • Douglas • Echols • Effingham • Elbert • Emanuel • Evans • Fannin • Fayette • Floyd • Forsyth • Franklin • Fulton • Gilmer • Glynn • Gordon • Greene • Gwinnett • Habersham • Hall • Hancock • Haralson • Harris • Hart • Heard • Henry • Houston • Irwin • Jackson • Jasper • Johnson • Jones • Lamar • Laurens • Lee • Liberty • Lincoln • Long • Lumpkin • Madison • Marion • McDuffie • McIntosh • Meriwether • Monroe • Morgan • Murray • Muscogee • Newton • Oconee • Oglethorpe • Paulding • Peach • Pickens • Pike • Polk • Putnam • Quitman • Rabun • Randolph • Richmond • Rockdale • Schley • Spalding • Stephens • Stewart • Sumter • Talbot • Taliaferro • Tattnall • Taylor • Terrell • Tift • Toombs • Towns • Treutlen • Troup • Turner • Twiggs • Union • Upson • Walton • Warren • Washington • Wayne • White • Worth

Idaho

Ada • Canyon

Illinois

Bond • Boone • Bureau • Calhoun • Cook • DeKalb • Douglas • DuPage • Edgar • Ford • Fulton • Grundy • Iroquois • Jersey • Kane • Kankakee • Kendall • Lee • Livingston • Logan • Macon • Macoupin • Madison • Marshall • Mason • McHenry • McLean • Menard • Mercer • Monroe • Morgan • Moultrie • Ogle • Peoria • Piatt • Putnam • Rock Island • Sangamon • St. Clair • Stark • Tazewell • Vermilion • Warren • Washington • White • Will • Winnebago • Woodford

Indiana

Adams • Allen • Benton • Blackford • Boone • Brown • Carroll • Cass • Clark • Clinton • Crawford • Dearborn • Decatur • DeKalb • Delaware • Fayette • Floyd • Fountain • Franklin • Gibson • Grant • Hamilton • Hancock • Harrison • Hendricks • Henry • Howard • Huntington • Jasper • Jefferson • Jennings • Johnson • Kosciusko • LaGrange • Lake • LaPorte • Madison • Marion • Marshall • Miami • Monroe • Montgomery • Morgan • Newton • Noble • Ohio • Parke • Porter • Posey • Pulaski • Putnam • Randolph • Ripley • Rush • Scott • Shelby • St. Joseph • Starke • Steuben • Switzerland • Tippecanoe • Tipton • Union • Vanderburgh • Vigo • Wabash • Warren • Warrick • Washington • Wayne • Wells • White • Whitley

Iowa

Black Hawk • Dallas • Johnson • Linn • Polk • Pottawattamie • Scott • Story

Kansas

Douglas • Franklin • Johnson • Leavenworth • Miami • Shawnee • Wyandotte

Kentucky

Anderson • Boone • Bourbon • Boyd • Bullitt • Campbell • Carroll • Carter • Clark • Fayette • Franklin • Grant • Greenup • Hardin • Harrison • Henderson • Henry • Jefferson • Jessamine • Kenton • Larue • Lawrence • Madison • Mason • Meade • Montgomery • Nelson • Oldham • Pendleton • Powell • Rowan • Scott • Shelby • Spencer • Woodford

Louisiana

Ascension • Assumption • Bossier • Caddo • East Baton Rouge • Iberia • Iberville • Jefferson • Lafayette • Lafourche • Livingston • Orleans • St. Bernard • St. Charles • St. James • St. John the Baptist • St. Landry • St. Martin • St. Mary • St. Tammany • Tangipahoa • Terrebonne • West Baton Rouge

Maine

Androscoggin • Aroostook • Cumberland • Franklin • Hancock • Kennebec • Knox • Lincoln • Oxford • Penobscot • Piscataquis • Sagadahoc • Somerset • Waldo • York

Maryland

Allegany • Anne Arundel • Baltimore • Baltimore City • Calvert • Caroline • Carroll • Cecil • Charles • Dorchester • Frederick • Garrett • Harford • Howard • Kent • Montgomery • Prince George's • Queen Anne's • St. Mary's • Talbot • Washington • Wicomico • Worcester

Massachusetts

Bristol • Essex • Hampden • Middlesex • Norfolk • Plymouth • Suffolk • Worcester

Michigan

Allegan • Antrim • Arenac • Bay • Benzie • Berrien • Branch • Calhoun • Cass • Clare • Genesee • Gladwin • Grand Traverse • Gratiot • Hillsdale • Jackson • Kalamazoo • Kalkaska • Kent • Lapeer • Leelanau • Livingston • Macomb • Midland • Missaukee • Monroe • Muskegon • Newaygo • Oakland • Oceana • Ogemaw • Otsego • Ottawa • Roscommon • Saginaw • Sanilac • Shiawassee • St. Clair • St. Joseph • Tuscola • Washtenaw • Wayne • Wexford

Mississippi

Benton • Calhoun • Chickasaw • Clay • DeSoto • Panola • Pontotoc • Prentiss • Tippah • Tunica • Webster

Missouri

Benton • Boone • Buchanan • Cass • Christian • Clay • Cole • Crawford • Dade • Dallas • Franklin • Greene • Henry • Hickory • Jackson • Jasper • Jefferson • Johnson • Lawrence • Lincoln • Platte • Polk • Ray • St. Charles • St. Louis • St. Louis City • Stone • Warren • Washington • Webster • Wright

Nebraska

Dodge • Douglas • Lancaster • Sarpy • Washington

Nevada

Carson City • Clark • Washoe

New Hampshire

Belknap • Hillsborough • Merrimack • Rockingham • Strafford

New Jersey

Atlantic • Bergen • Burlington • Camden • Cape May • Cumberland • Essex • Gloucester • Hudson • Hunterdon • Mercer • Middlesex • Monmouth • Morris • Ocean • Passaic • Salem • Somerset • Sussex • Union • Warren

New Mexico

Bernalillo • Cibola • Sandoval • Socorro • Torrance • Valencia

New York

Albany • Bronx • Broome • Cayuga • Chemung • Chenango • Columbia • Cortland • Delaware • Dutchess • Genesee • Greene • Jefferson • Kings • Lewis • Livingston • Madison • Monroe • Nassau • New York • Oneida • Onondaga • Ontario • Orange • Orleans • Oswego • Putnam • Queens • Rensselaer • Richmond • Rockland • Saratoga • Schenectady • Schuyler • Seneca • St. Lawrence • Steuben • Suffolk • Sullivan • Tioga • Tompkins • Ulster • Wayne • Westchester • Yates

North Carolina

Alamance • Alexander • Alleghany • Buncombe • Burke • Cabarrus • Caldwell • Caswell • Catawba • Chatham • Cleveland • Cumberland • Davidson • Davie • Durham • Edgecombe • Forsyth • Franklin • Gaston • Gates • Granville • Guilford • Harnett • Haywood • Henderson • Hoke • Iredell • Johnston • Lee • Lenoir • Lincoln • McDowell • Mecklenburg • Montgomery • Moore • Nash • Orange • Person • Polk • Randolph • Richmond • Robeson • Rockingham • Rowan • Rutherford • Sampson • Scotland • Stanly • Stokes • Surry • Union • Vance • Wake • Wayne • Wilkes • Wilson • Yadkin

Ohio

Adams • Allen • Ashland • Ashtabula • Athens • Auglaize • Belmont • Brown • Butler • Carroll • Champaign • Clark • Clermont • Clinton • Columbiana • Coshocton • Crawford • Cuyahoga • Darke • Defiance • Delaware • Erie • Fairfield • Fayette • Franklin • Fulton • Gallia • Geauga • Greene • Guernsey • Hamilton • Hancock • Hardin • Harrison • Henry • Highland • Hocking • Holmes • Huron • Jackson • Jefferson • Knox • Lake • Lawrence • Licking • Logan • Lorain • Lucas • Madison • Mahoning • Marion • Medina • Meigs • Mercer • Miami • Monroe • Montgomery • Morgan • Morrow • Muskingum • Noble • Ottawa • Paulding • Perry • Pickaway • Pike • Portage • Preble • Putnam • Richland • Ross • Sandusky • Scioto • Seneca • Shelby • Stark • Summit • Trumbull • Tuscarawas • Union • Van Wert • Vinton • Warren • Washington • Wayne • Williams • Wood • Wyandot

Oklahoma

Canadian • Cleveland • Creek • Kingfisher • Lincoln • Logan • Major • Marshall • Oklahoma • Osage • Pawnee • Seminole • Tulsa • Wagoner

Pennsylvania

Adams • Allegheny • Armstrong • Beaver • Bedford • Berks • Blair • Bradford • Bucks • Butler • Cambria • Cameron • Carbon • Centre • Chester • Clarion • Clearfield • Clinton • Columbia • Crawford • Cumberland • Dauphin • Delaware • Elk • Erie • Fayette • Forest • Franklin • Fulton • Greene • Huntingdon • Indiana • Jefferson • Juniata • Lackawanna • Lancaster • Lawrence • Lebanon • Lehigh • Luzerne • Lycoming • McKean • Mercer • Mifflin • Monroe • Montgomery • Montour • Northampton • Northumberland • Perry • Philadelphia • Pike • Potter • Schuylkill • Snyder • Somerset • Sullivan • Susquehanna • Tioga • Union • Venango • Warren • Washington • Wayne • Westmoreland • Wyoming • York

Rhode Island

Bristol • Kent • Newport • Providence • Washington

South Carolina

Abbeville • Anderson • Beaufort • Berkeley • Charleston • Cherokee • Chester • Dorchester • Greenville • Greenwood • Lancaster • Laurens • Oconee • Pickens • Spartanburg • Sumter • Union • York

Tennessee

Cheatham • Davidson • Dickson • Fayette • Maury • Robertson • Rutherford • Shelby • Sumner • Tipton • Trousdale • Williamson

Texas

Anderson • Aransas • Archer • Armstrong • Atascosa • Austin • Bailey • Bandera • Bastrop • Baylor • Bee • Bexar • Blanco • Borden • Bosque • Brazoria • Brazos • Briscoe • Brooks • Burleson • Burnet • Caldwell • Callahan • Cameron • Camp • Carson • Cass • Castro • Chambers • Cherokee • Clay • Cochran • Coke • Coleman • Collin • Comal • Concho • Cooke • Coryell • Crosby • Dallas • Dawson • Deaf Smith • Delta • Denton • DeWitt • Dickens • Dimmit • Donley • Duval • Ector • El Paso • Ellis • Falls • Fannin • Fayette • Fisher • Floyd • Fort Bend • Franklin • Freestone • Galveston • Garza • Gillespie • Glasscock • Goliad • Gonzales • Gray • Grayson • Gregg • Grimes • Guadalupe • Hale • Hall • Hamilton • Hardin • Harris • Harrison • Hartley • Haskell • Hays • Henderson • Hidalgo • Hill • Hockley • Hood • Hopkins • Houston • Hunt • Hutchinson • Irion • Jack • Jefferson • Jim Hogg • Jim Wells • Johnson • Jones • Karnes • Kaufman • Kendall • Kenedy • Kent • Kerr • Kimble • Kleberg • Knox • La Salle • Lamb • Lampasas • Lavaca • Lee • Leon • Liberty • Limestone • Llano • Lubbock • Lynn • Madison • Marion • Martin • Mason • Matagorda • McCulloch • McLennan • McMullen • Medina • Menard • Midland • Milam • Mills • Montague • Montgomery • Moore • Morris • Motley • Nacogdoches • Navarro • Nolan • Nueces • Oldham • Orange • Palo Pinto • Panola • Parker • Polk • Potter • Rains • Randall • Reagan • Real • Red River • Refugio • Roberts • Robertson • Rockwall • Runnels • Rusk • San Jacinto • San Patricio • San Saba • Schleicher • Shackelford • Shelby • Smith • Somervell • Starr • Sterling • Stonewall • Sutton • Swisher • Tarrant • Taylor • Terry • Throckmorton • Travis • Trinity • Tyler • Upshur • Van Zandt • Walker • Waller • Washington • Webb • Wharton • Wheeler • Willacy • Williamson • Wilson • Wise • Wood • Young • Zavala

Utah

Box Elder • Cache • Davis • Duchesne • Morgan • Rich • Salt Lake • Summit • Tooele • Utah • Wasatch • Weber

Virginia

Alexandria City • Amelia • Arlington • Botetourt • Caroline • Charles City • Chesterfield • Colonial Heights City • Craig • Danville City • Dinwiddie • Essex • Fairfax • Fairfax City • Falls Church City • Fauquier • Fluvanna • Franklin • Franklin City • Frederick • Fredericksburg City • Gloucester • Goochland • Grayson • Greene • Hampton City • Hanover • Henrico • Henry • Hopewell City • Isle of Wight • James City • King and Queen • King George • King William • Lancaster • Loudoun • Louisa • Madison • Manassas City • Manassas Park City • Martinsville City • Mathews • Middlesex • Nelson • New Kent • Newport News City • Northumberland • Petersburg City • Pittsylvania • Poquoson City • Portsmouth City • Powhatan • Prince George • Prince William • Radford City • Richmond City • Roanoke • Roanoke City • Salem City • Spotsylvania • Stafford • Sussex • Westmoreland • Williamsburg City • York

Washington

King • Kitsap • Mason • Pierce • Snohomish • Thurston

West Virginia

Berkeley • Cabell • Harrison • Jefferson • Kanawha • Marion • Marshall • Mason • Monongalia • Ohio • Putnam • Wood

Wisconsin

Kenosha • Milwaukee • Ozaukee • Racine • Sheboygan • Walworth • Washington • Waukesha

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 1-855-344-2209. Someone who speaks English/Language 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 1-855-344-2209. 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 1-855-344-2209。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 1-855-344-2209。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 1-855-344-2209. 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 1-855-344-2209. 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 quý vị cần thông dịch viên xin gọi 1-855-344-2209. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-344-2209. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-344-2209. 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 1-855-344-2209. 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 1-855-344-2209. 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 1-855-344-2209 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 1-855-344-2209. 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 1-855-344-2209. 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 1-855-344-2209. 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 1-855-344-2209. 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。通訳をご用命になるには、1-855-344-2209. 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 ‘ōlelo kā mākou i mea e pane ‘ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā‘au lapa‘au paha. I mea e loa‘a ai ke kōkua māhele ‘ōlelo, e kelepona mai iā mākou ma 1-855-344-2209. E hiki ana i kekahi mea ‘ōlelo Pelekānia/‘Ōlelo ke kōkua iā ‘oe. He pōmaika‘i manuahi kēia.

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Form CMS-10802
(Expires 12/31/25)

Aetna Medicare Plan (PPO) Member Services

Method	Member Services – Contact Information
CALL 	Please call 1-855-344-2209 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. 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 9 PM ET, Monday through Friday.
WRITE 	Aetna Medicare PO Box 7082 London, KY 40742
WEBSITE 	Dow.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.