



January 1 – December 31, 2018

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2018. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

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

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. This document is available for free in Spanish.

Please contact our Customer Service at the telephone number printed on your member ID card for additional information. You may also call our general Customer Service center at 1-888-267-2637. (TTY users should call 711). Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

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

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2019. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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

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Getting started as a member

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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 get your Medicare health care and your prescription drug coverage through our plan, Aetna Medicare Plan (PPO).

There are different types of Medicare health plans. 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.

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

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of our plan.

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* booklet.

If you are confused or concerned or just have a question, please contact our plan’s Customer Service (phone numbers are printed on your member ID card).

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Section 1.3 Legal information about the *Evidence of Coverage***It's part of our contract with you**

This *Evidence of Coverage* is part of our contract with you about how our plan 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 our plan between January 1, 2018 and December 31, 2018.

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 our plan after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan 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 (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States

If you have Medicare because you have End-Stage Renal Disease (ESRD), you are not eligible for this plan in the first 30 months of becoming eligible for or entitled to Medicare (referred to as your “30 month coordination period”). After the 30-month coordination period, you are eligible for our plan.

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Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 The plan service area

Although Medicare is a Federal program, our plan 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. Addendum B at the back of this *Evidence of Coverage* lists the Aetna Medicare Plan (PPO) service areas.

If you 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 to you in your new location.

If you move, please contact Customer Service at the telephone number 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 2.4 U.S. citizen or lawful presence

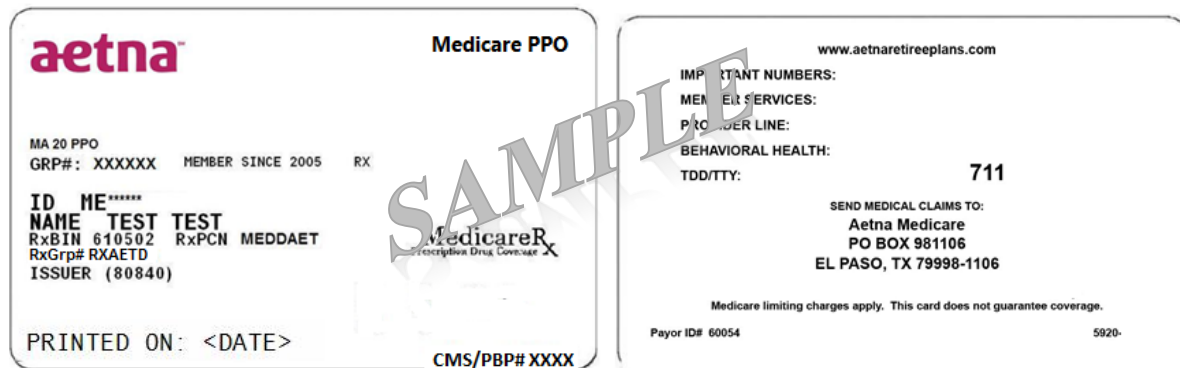
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify our plan if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any 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:

Chapter 1. Getting started as a member



As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Aetna Medicare Plan (PPO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on your member ID card.)

Section 3.2 The Provider & Pharmacy Directory: Network providers

The *Provider & Pharmacy Directory* lists our network providers and durable medical equipment suppliers.

What are “network providers”?

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. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. 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. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

Chapter 1. Getting started as a member

If you don't have your copy of the *Provider & Pharmacy Directory*, you can request a copy from Customer Service (phone numbers are printed on your member ID card). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider & Pharmacy Directory* at <http://www.aetnamedicaredocfind.com>. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Out-of-network providers must be eligible to receive payment under Medicare. To find a provider that participates with Original Medicare, go to <https://www.medicare.gov>.

Section 3.3 The *Provider & Pharmacy Directory*: Network Pharmacies

What are “network pharmacies”?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider & Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider & Pharmacy Directory* is located on our website at <https://www.aetnamedicare.com/findpharmacy>. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2018 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

The *Provider & 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 *Provider & Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are printed on your member ID card). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at <https://www.aetnamedicare.com/findpharmacy>.

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. 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 our plan's Drug List.

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

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We have included 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 (<http://www.aetnaretireplans.com>) or call Customer Service (phone numbers are printed on your member ID card).

Section 3.5	The <i>Part D Explanation of Benefits</i> (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs
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When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the “Part D EOB”).

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on your member ID card).

SECTION 4 Your monthly premium for our plan

Section 4.1	How much is your plan premium (if applicable)?
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Your coverage is provided through a contract with your former employer/union/trust. Your plan benefits administrator will let you know about your plan premium, if any.

If you have an Aetna plan premium and are billed directly by Aetna Medicare for the full amount of the premium, we will mail you a monthly invoice or an annual coupon book detailing your premium amount. If you have an Aetna plan premium and you are not billed directly by Aetna Medicare for this premium, please refer to your plan benefits administrator for any premium payment information.

In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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.

Chapter 1. Getting started as a member

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 send 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 Customer Service and ask for the “LIS Rider.” (Phone numbers for Customer Service are printed on your member ID card.)

In some situations, your plan premium could be more

Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is at least as good as Medicare’s standard drug coverage.) For these members, the Part D late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

- If you are required to pay the Part D late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 1, Section 5 *explains the Part D late enrollment penalty.*
- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

SECTION 5 Do you have to pay the Part D “late enrollment penalty”?

Section 5.1 What is the Part D “late enrollment penalty”?

Note: If you receive “Extra Help” from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a late enrollment penalty 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 amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

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The late enrollment penalty is added to your monthly premium (if applicable).

Your late enrollment penalty is considered part of your plan premium. If you do not pay your late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2	How much is the Part D late enrollment penalty?
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Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't 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 2018, this average premium amount is \$35.02. This amount may change for 2019.
- 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 \$35.02, which equals \$4.90. This rounds to \$4.90. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

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

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- 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.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your 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.

Section 5.3	In some situations, you can enroll late and not have to pay the penalty
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Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

Chapter 1. Getting started as a member

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. Medicare calls this “**creditable drug coverage.**” Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - Please note: If you receive a “certificate of creditable coverage” when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had “creditable” prescription drug coverage that expected to pay as much as Medicare’s standard prescription drug plan pays.
 - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
 - For additional information about creditable coverage, please look in your *Medicare & You 2018 Handbook* or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 5.4	What can you do if you disagree about your Part D late enrollment penalty?
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If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on your member ID card).

Important: Do not stop paying your late enrollment penalty while you’re waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

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 and how to pay it. 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.**

Chapter 1. Getting started as a member**Section 6.2 How much is the extra Part D amount?**

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2016 was:	If you were married but filed a separate tax return and your income in 2016 was:	If you filed a joint tax return and your income in 2016 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$13.00
Greater than \$107,000 and less than or equal to \$133,500		Greater than \$214,000 and less than or equal to \$267,000	\$33.60
Greater than \$133,500 and less than or equal to \$160,000		Greater than \$267,000 and less than or equal to \$320,000	\$54.20
Greater than \$160,000	Greater than \$85,000	Greater than \$320,000	\$74.80

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

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 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, (if applicable), many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than \$85,000 for an individual (or married individuals filing separately) or greater than \$170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- 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.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit <https://www.medicare.gov> on the Web or call 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 may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2018* gives information about the Medicare premiums in the section called “2018 Medicare Costs.” This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website (<https://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 7.1	There are several ways you can pay your plan premium (if applicable)
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Your coverage is provided through a contract with your former employer/union/trust. 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 or an annual coupon book detailing your premium amount. (You must also continue to pay your Medicare Part B premium.)

For members who have an Aetna plan premium and are billed directly by Aetna, there are several ways you can pay your plan premium. These options are listed below. You may inform us of your premium payment option choice or change your choice by calling Customer Service at the numbers printed on your member ID card.

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

Option 1: You can pay by check

If Aetna bills you directly for your total plan premium, you may decide to pay your monthly plan premium to us by check. Please make your check payable to the plan. 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 coupon in our office no later than the 8th of each month to prevent your account from becoming delinquent. All monthly plan premium payments should be sent to the address listed on your monthly invoice or payment coupons.

Coupon Book (If Applicable)

Your coupon book should arrive within 30 days of your selection or the date we received your enrollment application. Be sure to include your coupon with your check to ensure the appropriate credit is applied to your account. We reserve the right to charge up to \$35 for any returned bank items. In the event that you need a replacement coupon book or you wish to change your payment method, please call Customer Service for assistance (phone numbers are printed on your member ID card).

Option 2: You can pay by automatic withdrawal

If Aetna bills you directly for your total plan premium, you may decide to pay your monthly plan premium by an automatic withdrawal from your bank account by the Electronic Fund Transfer (EFT) option. Your plan premium will be automatically deducted from your bank account by the 6th day of every month. You may also have your plan premium charged to a credit card of your choice and the payment will be charged to your credit card by the 10th day of every month. If you are interested in enrolling in these programs, please contact Customer Service (phone numbers are printed on your member ID card).

Chapter 1. Getting started as a member

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

If you are billed directly by Aetna, your plan premium is due in our office by the first day of the month. If we have not received your premium payment by the tenth day of the month, we will do the following:

- For enrollees who are formally receiving “Extra Help” with payment toward their monthly plan premiums or whose premium payments are made up only of late enrollment penalty amounts, we will send you reminder notices of the premium amounts that are due to help you so you can keep your account up-to-date.
- For all other enrollees, we will send you a notice telling you that your plan membership may end if we do not receive your plan premium within three months of the due date. If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Customer Service are printed on your member ID card.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

If we end your membership with the plan because you did not pay your premium, and you don't currently have prescription drug coverage then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without “creditable” drug coverage for more than 63 days, you may have to pay a late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you may need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling Customer Service (phone numbers are printed on your member ID card) between 8 a.m. to 6 p.m. local time, Monday through Friday. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Chapter 1. Getting started as a member

Section 7.2 Can we change your monthly plan premium (if applicable) during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you before the change happens and the change will take effect on the date your plan renews.

If your plan requires you to pay a plan premium, 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 all or part of the member's monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. 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 premium, you may need to start paying or may be able to stop paying a late enrollment penalty. (The late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) 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 ever lose your low income subsidy (Extra Help), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

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

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**

Chapter 1. Getting started as a member

know what services and drugs are covered and the cost-sharing amounts for you. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, Workers' Compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on your member ID card).

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.

Read over the information we send you about any other insurance coverage you have

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 benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

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 Customer Service (phone numbers are printed on your member ID card).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected
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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.

Chapter 1. Getting started as a member

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like coverage under another employer group health plan), 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.

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 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 your family member is still working, their 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 your spouse is still working, their 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.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service

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(phone numbers are printed on your member ID card). 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.

CHAPTER 2

*Important phone numbers
and resources*

Chapter 2. Important phone numbers and resources

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SECTION 1 Aetna Medicare Plan (PPO) contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan’s Customer Service

For assistance with claims, billing or member card questions, please call or write to Aetna Medicare Plan (PPO) Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	Please call the telephone number printed on your member ID card or our general Customer Service center at 1-888-267-2637. Calls to this number are free. We’re available 8 a.m. to 6 p.m. local time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We’re available 8 a.m. to 6 p.m. local time, Monday through Friday.
WRITE	Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088
WEBSITE	http://www.aetnaretireplans.com

How to contact us when you are asking for a coverage decision 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. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	Please call the telephone number printed on your member ID card or our general Customer Service center at 1-888-267-2637. Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.
TTY	711 Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.
FAX	Please use the following fax number to submit expedited (fast) requests only: 1-860-754-5468
WRITE	Aetna Medicare Precertification Unit P.O. Box 14079 Lexington, KY 40512-4079
WEBSITE	https://www.aetnamedicare.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Medical Care – Contact Information
CALL	1-800-932-2159 for Expedited Appeals Only Calls to this number are free. We're available 7 days per week, 8 a.m. to 8 p.m. local time.
TTY	711 Calls to this number are free. We're available 7 days per week, 8 a.m. to 8 p.m. local time.
FAX	724-741-4953
WRITE	Aetna Medicare Part C Appeals and Grievances P.O. Box 14067 Lexington, KY 40512
WEBSITE	You can submit an appeal about our plan online. To submit an online appeal go to https://www.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, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If you have a problem about the plan's coverage or payment, you should look at the section above about making an appeal.) 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 the telephone number printed on your member ID card or our general customer service center at 1-888-267-2637. Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.
TTY	711 Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.
FAX	1-724-741-4956
WRITE	Aetna Medicare Grievance & Appeal Unit P.O. Box 14067 Lexington, KY 40512
AETNA WEBSITE	You can submit a complaint about our plan online at https://www.aetnamedicare.com .
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your 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 Part D Prescription Drugs – Contact Information
CALL	1-888-267-2637 Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday..
TTY	711 Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.
FAX	1-800-408-2386
WRITE	Aetna P.O. Box 7773 London, KY 40742
WEBSITE	https://www.aetnamedicare.com

How to contact us when you are making an appeal about your 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 making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-877-235-3755 Calls to this number are free. We're available 8 a.m. to 8 p.m. local time, 7 days a week.
TTY	711 Calls to this number are free. We're available 8 a.m. to 8 p.m. local time, 7 days a week.
FAX	724-741-4954
WRITE	Aetna Medicare Part D Appeal and Grievances P.O. Box 14579 Lexington, KY 40512
WEBSITE	You can submit an appeal online at https://www.aetnamedicare.com .

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	Please call the telephone number printed on your member ID card or our general customer service center at 1-888-267-2637. Calls to this number are free. We’re available 8 a.m. to 6 p.m. local time, Monday through Friday.
TTY	711 Calls to this number are free. We’re available 8 a.m. to 6 p.m. local time, Monday through Friday.
FAX	1-860-907-3984
WRITE	Aetna Medicare Pharmacy Grievance and Appeal Unit P.O. Box 14579 Lexington, KY 40512
AETNA WEBSITE	You can submit a complaint about our plan online at https://www.aetnamedicare.com
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, 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 Request – Contact Information
WRITE	For Prescription Drug Claims: Aetna Pharmacy Management P.O. Box 52446 Phoenix, AZ 85072-2446 For Medical Claims: Aetna P.O. Box 981106 El Paso, TX 79998-1106

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

<https://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 booklets 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 our plan:

- **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to <https://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, print it out, and send it to 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.)

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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 *Evidence of Coverage* for the name and contact information for the State Health Insurance Assistance Program in your state.**

A SHIP is independent (not connected with any insurance company or health plan). It is a 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 with your Medicare questions or problems. They 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 understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. **Refer to Addendum A at the back of this *Evidence of Coverage* 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 the Federal government. This organization is 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. Social Security handles the enrollment process for 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 7:00 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 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified 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. **Contact information is in Addendum A in the back of this *Evidence of Coverage*.**

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

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.

People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

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 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter 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.

- While you are at the pharmacy, you can ask the pharmacist to contact Aetna at the number on your 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 listed below.

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

Method	Best Available Evidence – Contact Information
WRITE	Aetna Medicare Department Attention: BAE P.O. Box 14088 Lexington, KY 40512-4088
FAX	1-888-665-6296
EMAIL	BAE/LISMailbox@aetna.com

Examples of evidence can be any of the following items:

- A copy of your Medicaid card that includes your name and an eligibility date during a month after June of the previous calendar year
- A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year
- A print out from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year
- A screen print from the state’s Medicaid systems showing Medicaid status during a month after June of the previous calendar year
- Other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year
- For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter
- If you are institutionalized and qualify for zero cost-sharing:
 - A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year
 - A copy of a state document that confirms Medicaid payment on your behalf to the facility for a full calendar month after June of the previous calendar year
 - A screen print from the state’s Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year
- Medicare and additional SSA documents that supports a beneficiary’s LIS cost-sharing level:

- Deeming notice – pub.no. 11166 (purple notice)
 - Auto-enrollment notice – – Prospective only pub.no.11154 (yellow notice)
 - Auto-enrollment notice – Retroactive and Prospective pub.no.11429 (yellow notice)
 - Full-facilitated notice – pub.no. 11186 (green notice)
 - Partial-facilitated notice – pub.no.11191 (green notice)
 - Copay change notice – pub.no.11199 (orange notice)
 - Reassignment notice – pub.no. 11208 and 11209 (blue notice)
 - MA Reassignment – pub. no. 11443 (blue notice)
 - LIS Choosers notice – pub. no. 11267 (tan notice)
 - Chooser Reminder notice – pub. no. 11465 (tan notice)
- 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 Customer Service if you have questions (phone numbers are printed on your member ID card).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not already receiving “Extra Help.” For brand name drugs, the 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 35% of the negotiated price and a portion the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your *Part D Explanation of Benefits* (Part D EOB) will show any discount provided. 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. The amount paid by the plan (15%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 56% of the price for generic drugs and you pay the remaining 44% of the price. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. If your Aetna Medicare PPO plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on your member ID card).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

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 50% discount on covered brand name drugs. Also, the plan pays 15% of the costs of brand drugs in the coverage gap. The 50% discount and the 15% 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. The name of your state ADAP is shown on Addendum A attached to this *Evidence of Coverage*. *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 are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. **Contact information for your state ADAP is shown on Addendum A attached to this *Evidence of Coverage*.**

What if you get “Extra Help” from Medicare to help pay your prescription drug costs?

Can you get the discounts?

No. If you get “Extra Help,” you already get coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn’t appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t

agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Addendum A at the end of this *Evidence of Coverage*) or 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.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs (SPAPs) 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 *Evidence of Coverage* to identify if there is an SPAP 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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 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	https://secure.rrb.gov/

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

Your Aetna coverage is provided through a contract with a former employer/union/trust. You (or your spouse) may also get medical coverage from another employer or retiree group. Call the benefits administrator if you have questions regarding coordination of your coverages. If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact that group’s benefits administrator. Call the benefits administrator if you have questions regarding coordination of your coverages. You can also call Aetna’s Customer Service if you have any questions. (Phone numbers for Customer Service are printed on your member ID card.). 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.

CHAPTER 3

*Using the plan's coverage for your
medical services*

Chapter 3. Using the plan's coverage for your medical services

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Chapter 3. Using the plan's coverage for your medical services

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

This chapter explains what you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, 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* benefits chart included with this *Evidence of Coverage*. It's described in Chapter 4 (*Medical Benefits, what is covered and what you pay*).

Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“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, and equipment that are covered by our plan. Your covered services for medical care are listed in the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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

As a Medicare health plan, we must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's *Schedule of Cost Sharing*** with this *Evidence of Coverage*.
- **The care you receive is considered 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.

Chapter 3. Using the plan's coverage for your medical services

- **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 & Pharmacy Directory*.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - **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
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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. Your network PCP will appear on your ID card. If your ID card does not show a PCP 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 & Pharmacy Directory* or access our website at <http://www.aetnamedicaredocfind.com> for a complete listing of PCPs in your area.

Chapter 3. Using the plan's coverage for your medical services

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. Your PCP will help you find a specialist and will arrange for covered services you get as a member of our plan.

Some of the services that the PCP will coordinate include:

- x-rays;
- laboratory tests;
- therapies;
- care from doctors who are specialists; and
- 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 your medical care, we recommend that you have your past medical records sent to your PCP’s office.

In some cases, your PCP 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”). Services and items requiring prior authorization are listed in the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

How do you choose your network PCP?

You can select your PCP by using the *Provider & Pharmacy Directory*, or by accessing our website at <http://www.aetnamedicaredocfind.com>, or getting help from Customer Service (phone numbers are on your member ID card).

However, you can change your PCP (as explained later in this section) for any reason, any time by contacting Customer Service at the number on the back cover of this booklet with your PCP choice.

If you select a PCP, the name and/or office telephone number of your PCP is printed on your membership card.

Changing your network 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 or you may pay more for covered services. Contact us immediately if your ID card does not show the PCP you want to use. We will update your file and send you a new ID card to reflect the change in PCP.

To change your PCP, call Customer Service at the number on your member ID card **before** you set up an appointment with a new PCP. When you call, be sure to tell Customer Service 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

Chapter 3. Using the plan's coverage for your medical services

PCP you want to switch to is accepting new patients. Customer Service 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.

As a member of our plan, you don't need to use a PCP to provide a referral. You may go directly to a network specialist. If you do choose to use 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. Please refer to your *Provider & Pharmacy Directory* or access our website at <http://www.aetnamedicaredocfind.com> for a complete listing of PCPs and other participating providers in your area.

Prior Authorization Process

In some cases, your provider 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”). Your PCP or other provider is responsible for getting prior authorization. Services and items requiring prior authorization are listed in the *Schedule of Cost Sharing* included with this *Evidence of Coverage*. 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 getting services from out-of-network providers to confirm that the service is covered by your plan and to understand your cost-sharing responsibility.

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. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave 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.

Chapter 3. Using the plan's coverage for your medical services

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If 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 an appeal of our decision.
- If you find out that your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

You may contact Customer Service at the number on your ID card for assistance in selecting a new PCP or to identify other Aetna Medicare Plan (PPO) participating providers. You may also look up participating providers using the *Provider & Pharmacy Directory* or at our website at <http://www.aetnamedicaredocfind.com>. If you choose to continue using a provider who is no longer part of our network, you may pay more for covered services.

Section 2.3	How to get care from out-of-network providers
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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 network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** 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

Chapter 3. Using the plan's coverage for your medical services

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.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you will not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get covered 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 loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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.
- **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 Customer Service at the number on your member ID card.

Chapter 3. Using the plan's coverage for your medical services

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

Our plan also covers emergency medical care if you receive the care outside of the United States. Please see the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. 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 follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2	Getting care when you have an urgent need for services
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What are “urgently needed services”?

“Urgently needed services” are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care.

Chapter 3. Using the plan's coverage for your medical services

When circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, proceed to the nearest urgent care center for immediate treatment.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

Our plan covers urgently needed medical services if you receive the care outside of the United States.

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: <http://www.aetnaretireplans.com> for information on how to obtain needed care during a disaster.

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

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

Our plan covers all medical services that are medically necessary, are listed in the plan's *Schedule of Cost Sharing* included with this *Evidence of Coverage*, and are obtained consistent

Chapter 3. Using the plan's coverage for your medical services

with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on your member ID card).

For covered services that have a benefit limitation, you 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 Customer Service 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"?
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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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. 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.*

Once Medicare approves the study, 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. 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.

Chapter 3. Using the plan's coverage for your medical services

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on your member ID card) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your 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.

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 we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

Chapter 3. Using the plan's coverage for your medical services

- 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 and services the study gives you or any participant for free.
- 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 reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<https://www.medicare.gov>). 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 covered in a “religious non-medical health care institution”

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

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.

Chapter 3. Using the plan's coverage for your medical services

- 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 apply. See the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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?
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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 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 our plan we will transfer ownership of certain DME items. Call Customer Service (phone numbers are printed on your member ID card) 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. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments for the item after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4

*Medical Benefits
(what is covered and what you pay)*

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

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

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

This chapter focuses on your covered services and what you pay for your medical benefits. It describes a *Medical Benefits Chart* that lists your covered services and shows how much you will pay for each covered service as a member of our plan. The *Schedule of Cost Sharing* is included with and is part of this *Evidence of Coverage*. 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.

- The “**deductible**” is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- A “**copayment**” is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The *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. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is your plan deductible (if applicable)?

Your plan’s deductible (if applicable) is shown on page 1 of the *Schedule of Cost Sharing* included with this *Evidence of Coverage*. This is the amount you have to pay out-of-pocket before our plan pays its share for your covered medical services. 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. The services not subject to the deductible may vary based on whether they are received from in-network or out-of-network providers. Refer to page 1 of the *Schedule of*

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Cost Sharing included with this *Evidence of Coverage* 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 are two different limits on what you have to pay out-of-pocket for covered medical services. These amounts are shown on page 1 of your *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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

As a member of our plan, 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. 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

Chapter 4. Medical Benefits (what is covered and what you 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. You will generally have higher copays when you obtain care from out-of-network providers.
- 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 obtain 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 obtain 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 obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on your member ID card).

**SECTION 2 *Medical Benefits-* find out what is covered for you
and how much you will pay**

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

The *Schedule of Cost Sharing* included with this *Evidence of Coverage* lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart 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, and equipment) *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 our plan.

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

- Covered services that need approval in advance to be covered as in-network services are noted 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 2018 Handbook*. View it online at <https://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/coinsurance will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.

See the *Schedule of Cost Sharing* included with this *Evidence of Coverage* for details.

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

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 generally not covered by this plan. If a service is “excluded,” it means that the plan doesn’t cover the service.

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. We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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 booklet.)

All exclusions or limitations on services are described in the *Schedule of Cost Sharing* or in the chart 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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more

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Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
plan and Original Medicare to not be generally accepted by the medical community.		information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
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.

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Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		<ul style="list-style-type: none"> • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.		✓ Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered. Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>
Home-delivered meals		✓ Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i> .
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		for people with diabetic foot disease.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i> .
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture		✓ Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>
Naturopath services (uses natural or alternative treatments).	✓	
Services provided to veterans in Veterans Affairs (VA) facilities.		✓ When emergency services are received at VA hospital and the VA cost sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
Compression Stockings		✓ Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>

*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.

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

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

**Did you know there are programs to help people pay for their drugs?**

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

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 send 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 Customer Service and ask for the “LIS Rider.” (Phone numbers for Customer Service are printed on your member ID card.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs
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This chapter **explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, our plan also covers some drugs under the plan’s medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The *Schedule of Cost Sharing* included with this *Evidence of Coverage* tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 (*What if you’re in Medicare-certified hospice*). For information on hospice coverage and Part C, see the hospice section of the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

The following sections discuss coverage of your drugs under the plan’s Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

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

Section 1.2 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 your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, 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.

Our network includes pharmacies that offer standard cost-sharing and may include pharmacies that offer preferred cost-sharing (if included in your plan). You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing (if included in your plan). The *Prescription Drug Schedule of Cost Sharing* enclosed with this *Evidence of Coverage* shows both standard and preferred cost-sharing (if included in your plan).

Section 2.2 Finding network pharmacies**How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your *Pharmacy & Pharmacy Directory*, visit our website (<https://www.aetnamedicare.com/findpharmacy>), or call Customer Service (phone numbers are printed on your member ID card).

You may go to any of our network pharmacies. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing (if included in your plan) rather than a network pharmacy that offers standard cost-sharing. The *Provider & Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost-sharing (if included in your plan). You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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. 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 Customer Service (phone numbers are printed on your member ID card) or use the *Provider & Pharmacy Directory*. You can also find information on our website at <https://www.aetnamedicare.com/findpharmacy>.

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 are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- 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.

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

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (*Note:* This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider & Pharmacy Directory* or call Customer Service (phone numbers are printed on your member ID card).

Section 2.3	Using the plan's mail-order services
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For certain kinds of drugs, you can use the plan's network mail-order services. 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 Customer Service (phone numbers are printed on your member ID card).

Usually a mail-order pharmacy order will get to you in no more than 14 days. In the unlikely event that there is a significant delay with your mail-order prescription drug, our mail order service will work with you and a network pharmacy to provide you with a temporary supply of your mail-order prescription drug.

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 calling Customer Service (phone numbers are on your member ID card).

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 Customer Service (phone numbers are on your member ID card).

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

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. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Customer Service (phone numbers are on your member ID card).

Refills on mail order prescriptions.

For refills of your drugs, you have the option to sign up for an automatic refill program called *AetnaRx Autofill*. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of *AetnaRx Autofill* that automatically prepares mail order refills, please contact us by calling Customer Service (phone numbers are on your member ID card)

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling Customer Service (phone numbers are on your member ID card).

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.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider & Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information (phone numbers are printed on your member ID card).

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2. For certain kinds of drugs, you can use the plan's network **mail-order services**. 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. See Section 2.3 for more information about using our mail-order services.

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. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).
- If you are traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.
- If you receive a Part D prescription drug dispensed by an out-of-network institutional-based pharmacy while you are in the emergency department, provider-based clinic, outpatient surgery or other outpatient setting.
- If you have received your prescription during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence.

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.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (Phone numbers for Customer Service are printed on your member ID card.) You may 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.

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 share of the cost) at the time you fill your prescription. You can ask us to

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

reimburse you for our share of the cost. (Chapter 7, Section 2.1 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 must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- or -- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

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 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.

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

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* included with this *Evidence of Coverage*.

Your tier structure will be one of the following:

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

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

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.

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2. Visit the plan's website (<http://www.aetnaretireplans.com>). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on your member ID card.)

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 help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever 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. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. 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, Section 6.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our Drug List. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will

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not work for you or has written “No substitutions” on your prescription for a brand name drug or has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization**.” Sometimes the requirement for getting approval in advance helps 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

Some plans may require you to try less costly but 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 the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3	Do any of these restrictions apply to your drugs?
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The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on your member ID card) or check our website (<http://www.aetnaretireplans.com>).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service 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, Section 6.2 for information about asking for exceptions.)

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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We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently 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, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- 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. The plan puts each covered drug into one of a number of different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- 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 things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.

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- 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 can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year**. The total supply will be for a maximum of a 91-day supply and may be up to a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 91-day supply and may be up to a 98-day supply of medication. (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 (LTC) facility and need a supply right away:**

We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition 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

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prescription override. This one-time override will provide you with temporary coverage (up to a 31-day supply) for the applicable drug(s).

To ask for a temporary supply, call Customer Service (phone numbers are printed on your member ID card).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service 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. (Phone numbers for Customer Service are printed on your member ID card.)

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 to be 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 to the rule. 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 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.

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, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service 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. (Phone numbers for Customer Service are printed on your member ID card.)

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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 cost-sharing amount for brand 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 an enhanced drug benefit are not eligible for a tiering exception. (Enhanced drug coverage is offered 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 on page 1 of your *Prescription Drug Schedule of Cost Sharing* under the section "Enhanced Drug Benefit.")

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

Section 6.1 The Drug List can change during the year
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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.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?**How will you find out if your drug's coverage has been changed?**

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, 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. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan 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 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.

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

- Your provider will also know about this change, and can work with you to find another drug for your condition.

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. We won't pay for the drugs that are listed in this section (except for certain excluded drugs that may be covered under your plan's enhanced drug coverage*). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and 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.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

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

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

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- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject.
- Drugs when 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 offer supplemental coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). If included, this will be identified on page 1 of your *Prescription Drug Schedule of Cost Sharing* under the section “Enhanced Drug Benefit.” The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.)

In addition, if you are **receiving “Extra Help” from Medicare** to pay for your prescriptions, the “Extra Help” program will not pay for the drugs not normally covered. (Please refer to the plan’s Drug List or call Customer Service for more information. Phone numbers for Customer Service are printed on your member ID card.) 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 end of this booklet.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription 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 card with you?

If you don’t have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 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?

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 drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

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

Check your *Provider & Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (phone numbers are printed on your member ID card).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 91-day supply and may be up to a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or 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 to be

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

Section 9.3	What if you're also getting drug coverage from another employer/union/trust retiree group plan?
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Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, 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 are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree 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" and the choices you have for drug coverage.

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 these notices about creditable coverage, because you may need them 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 a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4	What if you're in Medicare-certified hospice?
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Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is 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 any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage

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under Part D Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

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. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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 medical 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 written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

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

Section 10.2 Medication Therapy Management (MTM) and other programs to help members manage their medications

We have programs that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take.

One program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications.

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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list 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 these programs, please contact Customer Service (phone numbers are printed on your member ID card).

CHAPTER 6

*What you pay for your Part D
prescription drugs*

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

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

**Did you know there are programs to help people pay for their drugs?**

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

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 send 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 Customer Service and ask for the “LIS Rider.” (Phone numbers for Customer Service are printed on your member ID card.)

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for your 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 coverage through an Enhanced Drug Benefit. See the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage* for more information.)

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the plan’s “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Customer Service (phone numbers are printed on your member ID card). You can also find the Drug List on our website at <http://www.aetnaretireplans.com>. The Drug List on the website is always the most current.

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

- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's Provider & Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Provider & Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2	Types of out-of-pocket costs you may pay for covered drugs
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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. The amount that you pay for a drug is called “cost-sharing,” and there are three ways you may be asked to pay.

- The “**deductible**” is the amount you must pay for drugs before our plan begins to pay its share.
- “**Copayment**” means that you pay a fixed amount each time you fill a prescription.
- “**Coinsurance**” means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2	What you pay for a drug depends on which “drug payment stage” you are in when you get the drug
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Section 2.1	What are the drug payment stages for our plan members?
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As shown in the table below, there are “drug payment stages” for your prescription drug coverage under our plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium (if applicable) regardless of the drug payment stage.

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

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>The amounts you pay during these stages are listed in <i>the Prescription Drug Schedule of Cost Sharing</i> included with this <i>Evidence of Coverage</i>.</p>			
<p>If your plan has a deductible: During this stage, you pay the full cost of your Part D drugs. You stay in this stage until you have paid the amount of your deductible.</p> <p>If your plan has no deductible: Because there is no deductible for the plan, this payment stage does not apply to you.</p> <p>(Details are in Section 4 of this chapter.)</p>	<p>If your plan has a deductible: After you (or others on your behalf) have met your plan deductible, the plan pays its share of the costs of your drugs and you pay your share.</p> <p>If your plan has no deductible: You begin in this stage when you fill your first prescription of the year.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$3,750.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>During this stage, you pay 35% of the price for brand name drugs plus a portion of the dispensing fee) and 44% of the price for generic drugs if your plan does not include supplemental coverage.</p> <p>If your plan includes supplemental coverage, your out-of-pocket costs will sometimes be lower than the costs described here. Your costs in the coverage gap are shown on the <i>Prescription Drug Schedule of Cost Sharing</i> included with this <i>Evidence of Coverage</i>.</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$5,000. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2018).</p> <p>(Details are in Section 7 of this chapter.)</p>

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 report called the “<i>Part D Explanation of Benefits</i>” (the “Part D EOB”)
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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.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the “Part D EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It 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 drugs 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 you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date
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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 when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when 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, you may give us copies of receipts for drugs that you have purchased. (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 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

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

- 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.
- **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 and help qualify you for catastrophic coverage. 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. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on your member ID card). Be sure to keep these reports. They are an important record of your drug expenses.

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

Section 4.1	If your plan includes a deductible, you stay in the Deductible Stage until you have paid any applicable cost-sharing for your Part D drugs
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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 of the year. Your plan's deductible amount (if applicable) is listed on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*. **You must pay the full cost of your drugs** until you reach the plan's deductible amount.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid your plan deductible amount (if applicable), you leave the Deductible Stage and move on to the next drug payment stage, which is 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
--

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 on *the Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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)
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

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

Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies. Some of our network pharmacies may also offer preferred cost-sharing (if included in your plan). You may go to either network pharmacies that offer preferred cost-sharing (if included in your plan) or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing (if included in your plan).

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

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

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

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table in the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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 you a full month’s supply of a covered drug. However your doctor can prescribe less than a month’s supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month’s supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month’s supply, you will not have to pay for the full month’s supply for certain drugs.

The amount you pay when you get less than a full month’s supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month’s supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month’s supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. 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.
 - Here’s an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is \$30. This means that the amount you pay per day for your drug is \$1. If you receive a 7 days’ supply of the drug, your payment will be \$1 per day multiplied by 7 days, for a total payment of \$7.

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

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply 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 (up to a 90-day) supply of a drug</i>
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For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

Refer to your *Prescription Drug Schedule of Cost Sharing* for a table that shows your costs for a long-term (up to a 90-day) supply of a drug.

As shown in the table in the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*, the amount of the copayment or coinsurance depends on which tier your drug is in.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Section 5.5	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$3,750
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You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$3,750 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The amount of the plan deductible you paid when you were in the Deductible Stage (if applicable).
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2018,

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

the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

Your former employer may offer 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 toward 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 “Enhanced Drug Benefit.” To find out which drugs our plan covers, refer to your formulary.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the \$3,750 limit in a year.

We will let you know if you reach this \$3,750 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, our plan may provide some coverage, or you receive a discount on brand name drugs and pay no more than 44% of the costs for generic drugs

Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$5,000
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The amount of your cost-sharing during the Coverage Gap Stage is shown on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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 35% 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 moves you through the coverage gap. Your cost for brand name drugs in the coverage gap is shown on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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 44% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (56%) 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

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

plan copay for the cost-sharing tier, and the amount you pay counts and move you through the coverage gap. Your cost for generic drugs in the coverage gap is shown on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*.

You continue paying the discounted price for brand name drugs and no more than 44% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2018, that amount is \$5,000.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$5,000, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs
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Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

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

When you add up your out-of-pocket costs, you **can 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 of this booklet):

- 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* 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.

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

- Some of the payments made by the Medicare Coverage Gap Discount Program are included. 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 \$5,000 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

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for 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 offered 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. Call Customer Service to let us know (phone numbers are printed on your member ID card).

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

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

- **We will help you.** The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$5,000 in out-of-pocket costs for the year, 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 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year
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You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$5,000 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 stage, the plan will pay most of the cost for your drugs. The amount you pay during the Catastrophic Coverage Stage is shown on the *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage*.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1	Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine
--------------------	--

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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

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

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

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible Stage (if applicable) and Coverage Gap Stage of your benefit (unless the vaccine is included in a drug tier for which plan supplemental coverage is offered).

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine and 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 vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

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

- You will be reimbursed the amount you paid less your normal 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 at your pharmacy, and then take it to your doctor’s office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will 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 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine 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 for applicable cost sharing. If you have any questions about how your vaccine is covered, you can call Customer Service (phone numbers are printed on your member ID card).

Section 8.2	You may want to call us at Customer Service before you get a vaccination
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on your member ID card.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us 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*

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

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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

Section 1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment
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Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, 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 also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this 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.

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. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should 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, you need to 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.
- At times 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 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. For more information about “balance billing,” go to Chapter 4, Section 1.4.
- 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. (Retroactive 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 for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on your member ID card.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

Save your receipt and send a copy to us when you ask us 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

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

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

Section 2.1	How and where to send us your request for payment
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Send us your request for payment, along with 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 (<https://www.aetnamedicare.com>) or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on your member ID card.)

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

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

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

You must submit your medical claims to us within one calendar year 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 receipts to us at this address:

Aetna Pharmacy Management
P.O. 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.

Contact Customer Service if you have any questions (phone numbers are printed on your member ID card). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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 for getting the care or drug, 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. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that

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

explains the reasons why we are not sending the payment you have requested 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 you don't agree with 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.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage (if applicable) and Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

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

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible Stage (if applicable) and Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

Chapter 8. Your rights and responsibilities

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Chapter 8. Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and 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 Customer Service (phone numbers are printed on the back cover of this booklet) or contact the Medicare Civil Rights Coordinator.

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 Customer Service at the number on the back of this booklet. 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. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service for additional information.

Sección 1.1	Debemos proporcionar información de una manera que funcione para usted (en idiomas distintos del inglés, en Braille, en letra grande o en otros formatos alternativos, etc.)
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Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios al Cliente (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de intérprete gratuitos disponibles para responder preguntas de los miembros con discapacidades o que no hablan inglés. Muchos documentos también están disponibles en español. También podemos ofrecerle información en Braille, en letra grande, u otros formatos alternativos sin costo alguno, si lo necesita. Tenemos que brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios al Cliente (los números de teléfono están impresos en la contraportada de este folleto) o comuníquese con el Coordinador de Derechos Civiles de Medicare.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, por favor llame para presentar una queja con el departamento de Servicios al Cliente al número que se encuentra en la parte posterior de este folleto. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto se incluye en esta

Chapter 8. Your rights and responsibilities

Evidencia de Cobertura o en este envío, o puede ponerse en contacto con Servicios al Cliente para obtener información adicional.

Section 1.2 We must treat you with fairness and respect at all times

You have the right to be treated with respect and recognition of your dignity and your right to privacy. Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on your member ID card). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

You have the right to choose a provider in the plan's network. Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on your member ID card). 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.

As a plan member, 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, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

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

Chapter 8. Your rights and responsibilities

- 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.
- The laws that protect your privacy give you rights related to getting 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.
- In most situations, if we 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 first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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 Customer Service (phone numbers are printed on your member ID card).

Notice of Privacy Practices

Para recibir esta notificación en español por favor llamar al número gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificación.

To receive this notice in Spanish, please call the toll-free Customer Service number on your ID card.

Chapter 8. Your rights and responsibilities

This Notice of Privacy Practices applies to Aetna’s insured health benefit plans. It does not apply to any plans that are self-funded by an employer. If you receive benefits through a group health insurance plan, your employer will be able to tell you if your plan is insured or self-funded. If your plan is self-funded, you may want to ask for a copy of your employer’s privacy notice.

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

Aetna¹ considers personal information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information.

When we use the term “personal information,” we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By “health information,” we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care).

This notice became effective on April 26, 2013.

How Aetna Uses and Discloses Personal Information

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and health care providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

Health Care Operations: We may use and disclose personal information during the course of running our health business – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management,

¹ For purposes of this notice, “Aetna” and the pronouns “we,” “us” and “our” refer to all of the HMO and licensed insurer subsidiaries of Aetna Inc., including but not limited to the entities listed on the last page of this notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

Chapter 8. Your rights and responsibilities

case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). In addition, we make claims information contained on our secure member website and telephonic claims status sites available to the subscriber and all covered dependents. We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, if you receive benefits through a group health insurance plan, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

Additional Reasons for Disclosure

We may use or disclose personal information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to your employer (if you receive your benefits through a group health insurance plan sponsored by your employer), when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.

Chapter 8. Your rights and responsibilities

- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Health Care

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Customer Service number on your ID card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Customer Service number on your ID card – or have your provider contact us.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

- for marketing purposes that are unrelated to your benefit plan(s),
- before disclosing any psychotherapy notes,
- related to the sale of your health information, and
- for other reasons as required by law.

If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Customer Service number on your ID card.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information:

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with health care operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
- You have the right to ask us to obtain a copy of health information that is contained in a “designated record set” – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other

Chapter 8. Your rights and responsibilities

decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.

- You have the right to ask us to amend health information that is in a “designated record set.” Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews.²

You may make any of the requests described above (if applicable), may request a paper copy of this notice, or ask questions regarding this notice by calling the toll-free Customer Service number on your ID card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address:

HIPAA Member Rights Team
Aetna Inc.
151 Farmington Avenue RT65
Hartford, CT 06156

You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Aetna’s Legal Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We

² Aetna does not participate in pretext interviews.

Chapter 8. Your rights and responsibilities

comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on your member ID card):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the *Provider & Pharmacy Directory*.
 - For a list of the pharmacies in the plan's network, see the *Provider & Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on your member ID card) or visit our website at <http://www.aetnaretireplans.com>.
- **Information about your coverage and the rules you must follow when using your coverage.**

Chapter 8. Your rights and responsibilities

- **You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.**
- In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
- To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
- If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on your member ID card).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns).
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

You have the right to participate with practitioners in making decisions about your health care. You have the right to get full information from your doctors and other health care providers when you go for medical care. 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:

Chapter 8. Your rights and responsibilities

- **To know about all of your choices.** This means that 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.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.
- **We follow specific rules to help us make your health a top concern:**
 - Our employees are not compensated based on denials of coverage.
 - Our plan does not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.
- **We’re committed to your well-being.** And we want you to have the information you need to get services and use your benefits. At <https://www.aetnamedicare.com>, we have tools and resources to help you get the most from your plan. You can learn more our Quality Management program (including goals and outcomes), and review our Owner’s Manual for Medicare members. The Owner’s Manual can be found in the site’s Connect with Us section. In the Manual you’ll find more on:
 - Health programs, screenings and vaccines to keep you healthy
 - How to get routine and preventive health care for women
 - How to get specialty care, hospital services, and behavioral health services (including inpatient, outpatient and partial hospitalization)
 - How to get care when your doctor’s office is closed
 - How we make coverage decisions
 - How we review new technology

Chapter 8. Your rights and responsibilities

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.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms (phone numbers are printed on your member ID card).
- **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 as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to 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.**

- If you are admitted to the hospital, they 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.

Chapter 8. Your rights and responsibilities

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact your State Health Insurance Assistance Program (SHIP). Contact information is on Addendum A at the back of this booklet.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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Coverage determinations are made based only on the appropriateness of care and service and plan coverage. Our Medical Management teams continually reviews new medical technologies, behavioral health treatment, prescription drugs and medical devices to plan coverage. New procedures and technology that are determined to be safe and effective may become covered by our plan and subject to all other terms and conditions, including medical necessity. Our plan does not reward or provide financial incentive to medical providers, our employees or other individuals for issuing denials of coverage.

You have the right to voice complaints or appeals about the organization or the care it provides. If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on your member ID card).

Section 1.8	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, 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:

Chapter 8. Your rights and responsibilities

- You can **call Customer Service** (phone numbers are printed on your member ID card).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **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 1.9 How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on your member ID card).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: <https://www.medicare.gov/Pubs/pdf/11534.pdf>.)
 - Or, 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.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on your member ID card). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on your member ID card).

Chapter 8. Your rights and responsibilities

- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **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 your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. 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. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **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) to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for 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. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The *Schedule of Cost Sharing* included with this *Evidence of Coverage* tells what you must pay for your medical services. The *Prescription Drug Schedule of Cost Sharing* included with this *Evidence of Coverage* tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

Chapter 8. Your rights and responsibilities

- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on your member ID card).
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - **You have a right to make recommendations regarding the organization's member rights and responsibilities policy.**
 - Phone numbers and calling hours for Customer Service are printed on your member ID card.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

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)**

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

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**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****BACKGROUND****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 types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using 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,” 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 for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and 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.

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

**SECTION 2 You can get help from government organizations that
are not connected with us**

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. 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 in Addendum A of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

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

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

**Section 3.1 Should you use the process for coverage decisions and
appeals? Or should you use the process for making
complaints?**

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

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

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us

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

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 a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) 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 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on your member ID card).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
 - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically

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forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **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.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (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 <https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. You may also download the form on our website at <https://www.aetnamedicare.com>). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** 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?

There are four different types of 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 to these services only*: home health care,

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skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on your member ID card). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Addendum A at the back of this booklet has the phone numbers for this program).

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



Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

<p>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</p>

This section is about your benefits for medical care and services. These benefits are described in the *Schedule of Cost Sharing* included with this *Evidence of Coverage*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
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.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
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.

- **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 a separate section of**

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this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

Section 5.2

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

(how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms

When a coverage decision involves your medical care, it is called an “**organization determination**.”

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Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

Legal Terms
A “fast coverage decision” is called an “expedited determination.”

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the

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process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have 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 your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell 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. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.***Deadlines for a “fast” coverage decision***

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

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- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **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 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **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 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

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**Section 5.3 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision
made by our plan)**

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “**reconsideration.**”

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on your member ID card) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at <https://www.aetnamedicare.com>.) 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.
- **If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from

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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 and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms
A “fast appeal” is also called an “ expedited reconsideration. ”

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, 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 do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - 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

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request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. 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 to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 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 denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

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Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us 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.
- 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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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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 what you requested**, we 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 or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **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.” It is also called “turning down your appeal.”)
 - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which 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.

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Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service *Schedule of Cost Sharing* included with this *Evidence of Coverage*. We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?


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 of this section. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, 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 yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is *yes* at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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

-  Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

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
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Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **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.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a “coverage determination.”

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

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*

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- Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 of this chapter.
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to Section 6.4 of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 6.4 of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 6.5 of this chapter.

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Section 6.2 What is an 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. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. 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 *List of Covered Drugs (Formulary)*.** (We call it the “Drug List” for short.)

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the exceptions cost-sharing tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

- The extra rules and restrictions on coverage for certain drugs may include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

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

- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of a number of 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.

Legal Terms

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **“tiering exception.”**

- 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).
- Coverage of any non-formulary drug is not eligible for a tiering exception.
- A drug included under an enhanced drug benefit is not eligible for a tiering exception. (Enhanced drug coverage is offered 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 on page 1 of your *Prescription Drug Schedule of Cost Sharing* under the section “Enhanced Drug 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.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

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(coverage decisions, appeals, complaints)**

- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception
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Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast coverage decision.” You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) 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. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form which is available on our website.

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

If your health requires it, ask us to give you a “fast coverage decision”

Legal Terms
A “fast coverage decision” is called an “ expedited coverage determination. ”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber 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 or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

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

- Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. 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 outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **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 to appeal.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. 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 organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, 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 to 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 organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

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

- **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 to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may

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

give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had 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 have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms
A “fast appeal” is also called an “ expedited redetermination. ”

- 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: 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

- If we are using the fast deadlines, 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 it.
 - 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. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals 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 to appeal our decision.

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

Deadlines for a “standard” appeal

- If we are using the standard deadlines, 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 you believe your health requires it, you should ask for “fast” appeal.
 - 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. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a 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 your appeal 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 and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
 - If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6	Step-by-step: How to make a Level 2 Appeal
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If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
<p>The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”</p>

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

Step 1: To make a Level 2 Appeal, 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.
- When you make an appeal to the Independent Review Organization, we will send the information we have 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 does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **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.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**

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

- If the Independent Review Organization approves a 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 approves a 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 your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. 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. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. 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 the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

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

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 has been decided, your doctor or the hospital staff will let you know.
- 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. This section tells you how to ask.

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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During your covered hospital stay, 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 whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on your member ID card). 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.

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
 - 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, and know who will pay for it.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
<p>The written notice from Medicare tells you how you can “request an immediate review.” Requesting an immediate review 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. (Section 7.2 below tells you how you can request an immediate review.)</p>

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

2. **You must sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
 - If you sign the notice more than two days before the day you leave the hospital, 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 Customer Service (phone numbers are printed on your member ID card) 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 it online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on your member ID card). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

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

Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

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 at the back of this booklet).

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital).
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal 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 about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that 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.

Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Customer Service (phone numbers are printed on of your member ID card) 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 <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

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* to your appeal, **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. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your**

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

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 turned down 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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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 stayed 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.

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

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- 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 a judge.

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 the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- 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?
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You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date.) 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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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

Legal Terms
A “fast” review (or “fast appeal”) is also called an “expedited appeal”.

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to 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.

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 will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply).
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”**

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When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

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. The complaint process is different from the appeal process. 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.

- **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.
- 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 reimburse you (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 with us that your planned hospital discharge date was medically appropriate.

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- The notice you get from the Independent Review Organization 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 a Level 3 Appeal, which is handled by a judge.

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 and make a third 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	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see the *Schedule of Cost Sharing* included with this booklet.

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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

- 1. You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling 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. (Section 8.3 below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Customer Service (phone numbers are printed on your member ID card) 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 see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

- 2. You must sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
 - 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 that it’s time to stop getting the 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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on your member ID card). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received 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 booklet.)

What should you ask for?

- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

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

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your 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.***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

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- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the “ Detailed Explanation of Non-Coverage. ”

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 to your appeal?

- 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). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- 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.

- This first appeal you make is “Level 1” of the appeals process. 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 another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another

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

look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 to your appeal?

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

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- 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 a judge.

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 reviewers turn down your Level 2 Appeal, you can choose whether to

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

accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- 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 in Section 8.3, 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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast” review (or “fast appeal”) is also called an “**expedited appeal**”.

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to 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.

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.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

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Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast 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 yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”

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,

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(coverage decisions, appeals, complaints)**

you can make a complaint. The complaint process is different from the appeal process. 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.

- **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.
- 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 reimburse you (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 continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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 of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in 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 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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

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minimum level, you cannot appeal any further. If the dollar value is high enough, 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 A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may or may not be over*** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge 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. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not be over*** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals 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 Appeals Council denies the review request, the appeals process *may or may not be over*.**

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- 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 Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice 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.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

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 A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **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. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

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Level 4 Appeal The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals 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 might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice 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.

- This is the last step of the appeals process.

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

-  **If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.**

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

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

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(coverage decisions, appeals, complaints)**

If you have any of these kinds of problems, you can “make a complaint”

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"> • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
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 how our Customer Service has treated you? • 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 Customer Service or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
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"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

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Complaint	Example
<p>Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)</p>	<p>The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us 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"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2

The formal name for “making a complaint” is “filing a grievance”

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 10.3

Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Please contact our Customer Service at the number on your member ID card for additional information. (For TTY assistance please

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call 711.) We're available 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are toll free. Customer Service also has free language interpreter services available for non-English speakers.

- **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.
 - Send your written complaint (also known as a grievance) to:
Aetna Medicare Grievance & Appeal Unit
P.O. Box 14067
Lexington, KY 40512
 - Be sure to provide all pertinent information or you may also download the form on our website at <https://www.aetnamedicare.com>. Under the "Choose a topic to help us find the right process for you" drop down menu, select "Quality of care or other services." This will allow you to select the "How to submit a complaint (grievance)" list which contains our printable complaint form and information on how to submit an online complaint.
 - The grievance must be submitted within 60 days of the event or incident. For written complaints, we will send you a written notice stating the result of our review. This notice will include a description of our understanding of your grievance, and our decision in clear terms. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for an extension or if we identify 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. An expedited or "fast" 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" grievance if you disagree with:
 - Our plan to take a 14-day extension on an organization determination or reconsideration, or
 - Our denial of your request to expedite an organization determination or reconsideration for health services or
 - Our denial of your request to expedite a coverage determination or redetermination for a prescription drug.
 - The expedited/fast complaint (grievance) process is as follows: You or an authorized representative may call or fax your complaint and mention that you want the fast, or expedited, grievance process. Call 1-888-267-2637 or fax your complaint to 1-866-604-7092. Upon receipt of the complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will notify you of

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

our decision by phone within 24 hours and send written follow-up shortly thereafter.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **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.**

Legal Terms
What this section calls a “fast complaint” is also called an “expedited grievance.”

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. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 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 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 let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4	You can also make complaints about quality of care to the Quality Improvement Organization
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Addendum A at the back of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5	You can also tell Medicare about your complaint
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You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to <https://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 have any other feedback or concerns, or if you feel the plan is not addressing your issue, please 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

Chapter 10. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan
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Ending your membership in our plan 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.
 - As a member of an employer/union/trust group retiree plan, you may voluntarily end your membership at other times as permitted by your plan sponsor. There are also certain specific times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends.

It is important that you consider your decision to disenroll from our plan carefully PRIOR to disenrolling. Since disenrollment from our plan could affect your employer or union health benefits, you could permanently lose your employer or union 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, some of the information in this chapter does not apply to you, because you are allowed to make plan changes at other times permitted by your plan sponsor. However, if you ever choose to discontinue your group retiree health plan coverage, and you move to an Individual Medicare Advantage plan, the information in this chapter will apply to you.

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 and during the annual Medicare Advantage Disenrollment Period. 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 plan) you are eligible to end your membership at any time through a Special Enrollment Period (see Section 2.3).

Section 2.1	You can end your membership during the general Medicare Advantage Annual Enrollment Period
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You can end your membership during the general Medicare Advantage **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the general Medicare Advantage Annual Enrollment Period?** This happens from October 15 to December 7.
 - **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
- Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.
- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

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

Section 2.2 **You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited**

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<https://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medicaid.
 - If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE) (where available).
 - If you are enrolled in an employer/union/trust group plan.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

Chapter 10. Ending your membership in the plan

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on your member ID card).
- You can find the information in the *Medicare & You 2018* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<https://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 3.1	Usually, you end your membership by enrolling in another plan
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It is important that you consider your decision to disenroll from our plan carefully PRIOR to disenrolling. Since disenrollment from our plan could affect your employer or union health benefits, you could permanently lose your employer or union health coverage. If you are considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on your member ID card).
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• An individual Medicare Advantage health plan.	<ul style="list-style-type: none">• Enroll in the new Medicare Advantage health plan. You will automatically be disenrolled from our plan when your new plan’s coverage begins.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">Original Medicare <i>with</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
<ul style="list-style-type: none">Original Medicare <i>without</i> a separate Medicare prescription drug plan.<ul style="list-style-type: none">Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	<ul style="list-style-type: none">Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are printed on your member ID card).You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

Section 4.1	Until your membership ends, you are still a member of our plan
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If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We 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, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on your member ID card.)
- 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 about 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:

- You can call **Customer Service** for more information (phone numbers are printed on your member ID card).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

Chapter 11. Legal notices

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SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. 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.

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 (MA) 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 <https://www.medicare.gov> website.

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

Chapter 11. Legal notices

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

Since your MA 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 MA 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 MA 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 MA 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 MA 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 MA 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 MA 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 MA 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 MA 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.

Chapter 11. Legal notices

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 MA 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 MA 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.

CHAPTER 12

Definitions of important words

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.

Annual Enrollment Period – A set time each fall when all Medicare members can change their health or drug plans or switch to Original Medicare. The general Medicare Advantage Annual Enrollment Period is from October 15 until December 7.

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. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

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 our plan, 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 haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$5,000 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Chapter 12. Definitions of important words

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

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. See Chapter 4, Section 1, 3 for information about your combined maximum out-of-pocket amount.

Complaint—The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services 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, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

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 drug is received. 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.

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 booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Chapter 12. Definitions of important words

Covered Services – The general term we use in this EOC 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 is personal care that can be provided by people who don’t have professional skills or training, such as 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.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service, or you can call the number printed on your member ID card.

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. This means you pay \$1 for each day’s supply when you fill your prescription.

Deductible – The amount (if applicable) you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs 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, loss of a limb, or loss of function of a limb.

Chapter 12. Definitions of important words

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) rendered 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 determination 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 preferred 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 the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

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 us 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 home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice - A member who has 6 months or less to live has the right to elect hospice. 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. The hospice will provide special treatment for your state.

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 income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan

Chapter 12. Definitions of important words

premium. For example, individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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 \$3,750.

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. For example, 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. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

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

Chapter 12. Definitions of important words

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Addendum A for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

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). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan (where available), a PACE plan (where available), or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage Plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2018.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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, 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).

Network – A group of doctors, hospitals, pharmacies, and other health care experts contracted by Aetna to provide covered services to its members (see Chapter 1, Section 3.2).

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. 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 we use 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. We call them “**network providers**” when they 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. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage Plan has made an organization determination when it makes a decision 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 booklet. Chapter 9 explains how to ask us for a coverage decision.

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.

Chapter 12. Definitions of important words

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, 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 with which we have not arranged 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 or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care 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, while getting the high-quality care they need. 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. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

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. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

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).

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers

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and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. Our plan does not require you to choose a plan provider to be your PCP, however we encourage you to do so. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services, or approval to get drugs that may or may not be on our formulary. Some in-network medical services are covered only if you, 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 getting services from out-of-network providers to confirm that the service is covered by your plan and to understand your cost-sharing responsibility. Covered services that need prior authorization are marked in the *Schedule of Cost Sharing* included with this *Evidence of Coverage*. Some drugs are covered only if you, your doctor, or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, 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. See Addendum A for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Reimbursement - Some plan sponsors offer retirees allowances towards the purchase of hearing aids or prescription eyewear as additional plan benefits. When these benefits are available, the member will generally pay out of pocket towards the hearing aid or eyewear and submit the paid receipt to Aetna for repayment. All reimbursement will be made to the member directly. Aetna will not send these reimbursements to a provider.

Chapter 12. Definitions of important words

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may 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 skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, 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.

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

Standard Cost-sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing (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 – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Addendum A – Important Contact Information for State Agencies

Alabama		
AIDS Drug Assistance Program (ADAP)	Alabama AIDS Drug Assistance Program 201 Monroe St. Ste. 1400 Montgomery, AL 36104 Fax: 1-334-206-6221 Website: http://www.adph.org/aids	Toll-free: 1-866-574-9964 TTY/TDD: 711
Alabama		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Alabama		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 201 Monroe St. Ste. 350, PO Box 301851 Montgomery, AL 36104 Fax: 1-334-242-5594 Website: http://www.alabamaageline.gov	Toll-free: 1-800-243-5463 TTY/TDD: 711
Alabama		
State Department of Insurance	Alabama Department of Insurance P O Box 303351, Montgomery, AL 36130 Fax: 1-334-956-7932 Website: http://www.aldoi.gov	Toll-free: 1-334-269-3550 Local: 1-334-241-4141 TTY/TDD: 711
Alabama		
State Medical Assistance Office	Alabama Medicaid Agency 501 Dexter Ave., Montgomery, AL 36104 Website: http://www.medicaid.alabama.gov	Toll-free: 1-800-362-1504 Local: 1-334-242-5000 TTY/TDD: 1-800-253-0799
Alaska		
AIDS Drug Assistance Program (ADAP)	Alaskan AIDS Assistance Association 1057 W Fireweed Ln., Ste. 102 Anchorage, AK 99503 Fax: 1-907-263-2051 Website: http://www.alaskan aids.org	Toll-free: 1-800-478-2437 In State Only Local: 1-907-263-2050 TTY/TDD: 711
Alaska		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
Alaska		

Addendum A: Important Contact Information for State Agencies

SHIP -- State Health Insurance Assistance Program	Medicare Information Office 400 Gambill Street, Ste 303 Anchorage, AK 99501 Fax: 1-907-269-2045 Website: http://medicare.alaska.gov	Toll-free: 1-800-478-6065 In State Only Local: 1-907-269-3680 TTY/TDD: 711
Alaska		
State Department of Insurance	State of Alaska Department of Commerce, Community, and Economic Development Division of Insurance Robert B Atwood Building, 550 West 7th Ave. Suite 1560 Anchorage, AK 99501 Fax: 1-907-269-7910 Website: https://www.insurance.alaska.gov	Toll-free: 1-800-467-8725 In State Only Local: 1-907-269-7900 TTY/TDD: 711
Alaska		
State Medical Assistance Office	Department of Health and Social Services- Public Assistance/Conduent Alaska Medicaid 1835 S. Bragaw St., Ste 200 Anchorage, AK 99508 Fax: 1-907-644-8126 Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Local: 1-907-334-2446 TTY/TDD: 1-888-431-5890
Arizona		
AIDS Drug Assistance Program (ADAP)	Arizona AIDS Drug Assistance Program 150 N. 18th Ave., Ste. 130 Phoenix, AZ 85007 Fax: 1-602-364-3263 Website: http://www.azdhs.gov/phs/hiv/adap/index.htm	Toll-free: 1-800-334-1540 Local: 1-602-364-3610 TTY/TDD: 711
Arizona		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668

Addendum A: Important Contact Information for State Agencies

Arizona		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson St., Site Code 950A Phoenix, AZ 85007 Fax: 1-602-542-6655 Website: https://des.az.gov/services/aging-and-adult/state-health-insurance/ship-offices	Toll-free: 1-800-432-4040 Local: 1-602-542-4446 TTY/TDD: 1-877-353-3771
Arizona		
State Department of Insurance	Arizona Department of Insurance 2910 N. 44th St., Ste. 210 Phoenix, AZ 85018 Fax: 1-602-364-2505 Website: http://insurance.az.gov	Toll-free: 1-800-325-2548 In State Only Local: 1-602-364-2499 TTY/TDD: 711
Arizona		
State Medical Assistance Office	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson St., Mail Drop 3800 Phoenix, AZ 85034 Fax: 1-602-258-4619 Website: http://www.azahcccs.gov/	Toll-free: 1-855-432-7587 Local: 1-602-417-5010 TTY/TDD: 711
Arkansas		
AIDS Drug Assistance Program (ADAP)	Arkansas Department of Health - STI/HIV/Hepatitis C Section AIDS Drug Assistance Program Arkansas Dept. of Health, 4815 W. Markham St. Little Rock, AR 72205 Fax: 1-501-661-2387 Website: http://www.healthy.arkansas.gov/programsService/infectiousDisease/hivStdHepatitisC/Pages/ADAP.aspx	Toll-free: 1-888-499-6544 Local: 1-501-661-2408 TTY/TDD: 711
Arkansas		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776

Addendum A: Important Contact Information for State Agencies

Arkansas		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIIP) 1200 W. Third St., Little Rock, AR 72201 Fax: 1-501-371-2781 Website: http://insurance.arkansas.gov/shiip.htm	Toll-free: 1-800-224-6330 Local: 1-501-371-2782 TTY/TDD: 711
Arkansas		
State Department of Insurance	Arkansas Insurance Department Consumer Services Division 1200 W. Third St., Little Rock, AR 72201 Fax: 1-501-371-2618 Website: http://www.insurance.arkansas.gov/	Toll-free: 1-800-852-5494 Local: 1-501-371-2640 TTY/TDD: 711
Arkansas		
State Medical Assistance Office	Arkansas Medicaid PO Box 1437, Slot S-341 Little Rock, AR 72203 Website: https://www.medicaid.state.ar.us	Toll-free: 1-800-482-5431 Local: 1-501-682-8233 TTY/TDD: 711
California		
AIDS Drug Assistance Program (ADAP)	Office of Aids; California Department of Public Health PO Box 997426, MS 7704, Sacramento, CA 95899 Fax: 1-844-421-8005 Website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_resourcespage.aspx	Toll-free: 1-844-421-7050 Local: 1-916-449-5900 TTY/TDD: 711
California		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
California		
SHIP -- State Health Insurance Assistance Program	California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Dr., Ste. 200 Sacramento, CA 95834 Fax: 1-714-560-0319 Website: http://www.aging.ca.gov/HICAP	Toll-free: 1-800-434-0222 In state only Local: 1-916-419-7500 TTY/TDD: 1-800-735-2929
California		
State Department of Insurance	California Department of Insurance 300 S. Spring St, South Tower, Los Angeles, CA 90013	Toll-free: 1-800-927-4357 In State Only Local: 1-213-897-8921

Addendum A: Important Contact Information for State Agencies

Website: http://www.insurance.ca.gov		TTY/TDD: 1-800-482-4833
California		
State Medical Assistance Office	California Department of Healthcare Services; (Medi-Cal) Covered California, P.O. Box 989725 West Sacramento, CA 95798 Website: http://www.dhcs.ca.gov/individuals/Pages/default.aspx	Toll-free: 1-800-541-5555 In State Only Local: 1-916-636-1980 TTY/TDD: 711
Colorado		
AIDS Drug Assistance Program (ADAP)	Colorado State Drug Assistance Program (ADAP)-Bridging the Gap 4300 Cherry Creek Drive South, A3-3800 Denver, CO 80246 Fax: 1-303-691-7736 Website: https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap	Local: 1-303-692-2716 TTY/TDD: 711
Colorado		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Colorado		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 2420 W. 26th Ave, Suite D450 Denver, CO 80211 Fax: 1-720-321-8851 Website: https://www.colorado.gov/pacific/dora/senior-healthcare-medicare	Toll-free: 1-888-696-7213 Local: 1-720-321-8850 TTY/TDD: 711

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Colorado		
State Department of Insurance	Department of Regulatory Agencies Division of Insurance 1560 Broadway, Suite 850 Denver, CO 80202 Fax: 1-303-894-7455 Website: www.dora.colorado.gov/insurance	Toll-free: 1-800-930-3745 Local: 1-303-894-7499 TTY/TDD: 711
Colorado		
State Medical Assistance Office	Health First Colorado 1570 Grant Street, Denver, CO 80203 Fax: 1-303-866-4411 Website: https://www.healthfirstcolorado.com/	Toll-free: 1-800-221-3943 Local: 1-303-866-2993 TTY/TDD: 711
Connecticut		
AIDS Drug Assistance Program (ADAP)	Connecticut AIDS Drug Assistance Program (CADAP) Department of Social Services Medical Operations Unit #4, 55 Farmington Avenue Hartford, CT 06105 Fax: 1-860-424-4822 Website: http://www.ct.gov/dss	Toll-free: 1-800-233-2503 In State Only Local: 1-860-509-8000 Out Of State Only / Dept. Of Public Health TTY/TDD: 711
Connecticut		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
Connecticut		
SHIP -- State Health Insurance Assistance Program	State Department on Aging 55 Farmington Ave., 12th Floor Hartford, CT 06134 Fax: 1-860-424-5301 Website: http://www.ct.gov/agingservices	Toll-free: 1-866-218-6631 In State Only Local: 1-860-424-5274 Out Of State Only TTY/TDD: 711
Connecticut		
State Department of Insurance	Connecticut Insurance Department 153 Market St., 7th Floor Hartford, CT 06103 Fax: 1-860-297-3800 Website: http://www.ct.gov/cid/site/default.asp	Toll-free: 1-800-203-3447 Local: 1-860-297-3800 TTY/TDD: 711

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Connecticut		
State Medical Assistance Office	Department of Social Services HUSKY Health Program 55 Farmington Ave., Hartford, CT 06015 Website: http://www.huskyhealth.com	Toll-free: 1-800-859-9889 Local: 1-877-284-8759 TTY/TDD: 711
Delaware		
AIDS Drug Assistance Program (ADAP)	Delaware HIV Consortium 100 W. 10th St., Ste. 415 Wilmington, DE 19801 Fax: 1-302-654-5472 Website: http://www.delawarehiv.org/services/adap/	Local: 1-302-654-5471 TTY/TDD: 711
Delaware		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Delaware		
SHIP -- State Health Insurance Assistance Program	Delaware Medicare Assistance Bureau 841 Silver Lake Blvd., Dover, DE 19904 Fax: 1-302-736-7979 Website: http://www.delawareinsurance.gov/dmab	Toll-free: 1-800-336-9500 Local: 1-302-674-7364 TTY/TDD: 711
Delaware		
State Department of Insurance	Delaware Department of Insurance 841 Silver Lake Blvd., Dover, DE 19904 Fax: 1-302-739-5280 Website: http://insurance.delaware.gov/	Toll-free: 1-800-282-8611 Local: 1-302-674-7300 TTY/TDD: 711
Delaware		
State Medical Assistance Office	Division of Medicaid & Medical Assistance 1901 N. Du Pont Highway, PO Box 906, Lewis Bldg. New Castle, DE 19720 Fax: 1-302-255-4425 Website: http://dhss.delaware.gov	Toll-free: 1-800-464-4357 Local: 1-302-255-9500 TTY/TDD: 711

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Delaware		
State Pharmaceutical Assistance Program	Delaware Prescription Assistance Program (DPAP) P.O. Box 950, New Castle, DE 19720 Website: http://dhss.delaware.gov/dhss/dmma/dpap.html	Toll-free: 1-800-996-9969 TTY/TDD: 711
District of Columbia		
AIDS Drug Assistance Program (ADAP)	DC AIDS Drug Assistance Program 899 N. Capitol St. NE, Suite 400 Washington, DC 20002 Fax: 1-202-673-4365 Website: http://doh.dc.gov/service/dc-aids-drug-assistance-program	Local: 1-202-671-4815 TTY/TDD: 711
District of Columbia		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
District of Columbia		
SHIP -- State Health Insurance Assistance Program	Health Insurance Counseling Project (HICP) 650 20th St. NW, Washington, DC 20052 Fax: 1-202-994-6441 Website: www.law.gwu.edu/health-insurance-counseling-project	Local: 1-202-994-6272 TTY/TDD: 711
District of Columbia		
State Department of Insurance	District of Columbia Insurance, Securities and Banking 810 First St. NE, Suite 701 Washington, DC 20002 Fax: 1-202-535-1196 Website: http://disb.dc.gov/	Local: 1-202-727-8000 TTY/TDD: 711
District of Columbia		
State Medical Assistance Office	District of Columbia Medicaid 441 4th Street, NW, 900S, Washington, DC 20001 Website: https://www.dc-medicaid.com/	Local: 1-202-727-5355 TTY/TDD: 711

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Florida		
AIDS Drug Assistance Program (ADAP)	HIV/AIDS Section 4052 Bald Cypress Way, Tallahassee, FL 32399 Website: http://www.floridahealth.gov/diseases-and-conditions/aids/adap	Toll-free: 1-800-352-2437 Local: 1-850-245-4334 TTY/TDD: 711
Florida		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Florida		
SHIP -- State Health Insurance Assistance Program	Florida SHINE 4040 Esplanade Way, Ste. 270 Tallahassee, FL 32399 Fax: 1-850-414-2150 Website: http://www.floridaSHINE.org	Toll-free: 1-800-963-5337 TTY/TDD: 711
Florida		
State Department of Insurance	Florida Office of Insurance Regulation 200 E. Gaines St., Tallahassee, FL 32399 Fax: 1-850-413-5098 Website: http://www.floir.com	Toll-free: 1-877-693-5236 Local: 1-850-413-3140 TTY/TDD: 1-800-640-0886
Florida		
State Medical Assistance Office	Agency for Health Care Administration 2727 Mahan Dr., Tallahassee, FL 32308 Website: http://www.myflorida.com/accessflorida	Toll-free: 1-866-762-2237 Local: 1-850-487-1111 TTY/TDD: 711
Georgia		
AIDS Drug Assistance Program (ADAP)	Georgia DHR, Division of Public Health - Georgia Department of Human Services: ADAP/HICP Manager 2 Peachtree St. NW, 14th floor Atlanta, GA 30303 Website: http://dph.georgia.gov/adap-program	Local: 1-404-463-0416 TTY/TDD: 711
Georgia		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Georgia		
SHIP -- State Health Insurance Assistance Program	GeorgiaCares 2 Peachtree St. NW, 33rd Floor Atlanta, GA 30303	Toll-free: 1-866-552-4464 TTY/TDD: 711

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Website: http://www.mygeorgiacares.org		
Georgia		
State Department of Insurance	Office of Insurance and Safety Fire Commissioner 2 Martin Luther King Jr. Dr., West Tower, Ste. 704 Atlanta, GA 30334 Fax: 1-404-657-8542 Website: http://www.oci.ga.gov	Toll-free: 1-800-656-2298 Local: 1-404-656-2070 TTY/TDD: 711
Georgia		
State Medical Assistance Office	Georgia Department of Community Health 2 Peachtree St. NW, Atlanta, GA 30303 Website: http://dch.georgia.gov/medicaid	Toll-free: 1-866-211-0950 Local: 1-404-656-4507 TTY/TDD: 711
Hawaii		
AIDS Drug Assistance Program (ADAP)	HIV Drug Assistance Program 3627 Kilauea Ave., Ste. 306 Honolulu, HI 96816 Website: http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/	Local: 1-808-733-9360 TTY/TDD: 711
Hawaii		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
Hawaii		
SHIP -- State Health Insurance Assistance Program	Hawaii SHIP No. 1 Capitol District, 250 S. Hotel St. Ste. 406 Honolulu, HI 96813 Fax: 1-808-586-0185 Website: http://hawaiiiship.org	Toll-free: 1-888-875-9229 Local: 1-808-586-7299 TTY/TDD: 711

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Hawaii		
State Department of Insurance	Department of Commerce and Consumer Affairs, Insurance Division 335 Merchant St., Rm. 213 Honolulu, HI 96813 Fax: 1-808-586-2806 Website: http://cca.hawaii.gov/ins/	Local: 1-808-586-2790 TTY/TDD: 711
Hawaii		
State Medical Assistance Office	Dept. of Human Services of Hawaii, Med-Quest Division PO Box 700190, Kapolei, HI 96709 Fax: 1-808-692-7224 Website: http://humanservices.hawaii.gov/mqd	Toll-free: 1-800-316-8005 Local: 1-808-524-3370 TTY/TDD: 711
Idaho		
AIDS Drug Assistance Program (ADAP)	IDAGAP (Idaho AIDS Drug Assistance Program) 450 W. State St., PO Box 83720 Boise, ID 83720 Fax: 1-208-332-7346 Website: http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	Local: 1-208-334-5612 TTY/TDD: 711
Idaho		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
Idaho		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Benefit Advisors (SHIBA) 700 W. State St., PO Box 83720 Boise, ID 83720 Fax: 1-208-334-4389 Website: http://www.doi.idaho.gov/shiba/default.aspx	Toll-free: 1-800-247-4422 TTY/TDD: 711

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Idaho		
State Department of Insurance	Idaho Department of Insurance 700 W. State St., 3rd Floor, PO Box 83720 Boise, ID 83720 Fax: 1-208-334-4398 Website: http://doi.idaho.gov/	Toll-free: 1-800-721-3272 In State Only Local: 1-208-334-4250 TTY/TDD: 711
Idaho		
State Medical Assistance Office	Department of Health and Welfare: Idaho Medicaid Program PO Box 83720, Boise, ID 83720 Fax: 1-866-434-8278 Website: healthandwelfare.idaho.gov	Toll-free: 1-877-456-1233 Local: 1-888-791-3004 TTY/TDD: 711
Idaho		
State Pharmaceutical Assistance Program	HIV State Prescription Assistance Program (IDAGAP) 450 W State ST, Boise, ID 83720 Fax: 1-208-334-5531 Website: http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	Toll-free: 1-800-926-2588 Local: 1-208-334-5943 TTY/TDD: 711
Illinois		
AIDS Drug Assistance Program (ADAP)	Illinois Dept of Public Health - AIDS Drug Assistance Program: ADAP Administrator 535 W. Jefferson Street, Springfield, IL 62761 Fax: 1-217-785-8013 Website: http://www.idph.state.il.us/health/aids/adap.htm	Toll-free: 1-800-825-3518 In State Only Local: 1-217-782-4977 TTY/TDD: 1-800-547-0466
Illinois		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776

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Illinois		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100 Springfield, IL 62702 Fax: 1-217-557-8457 Website: http://www.illinois.gov/aging/ship/Pages/default.aspx	Toll-free: 1-800-252-8966 TTY/TDD: 711
Illinois		
State Department of Insurance	Illinois Department of Insurance 320 West Washington St., 4th Floor Springfield, IL 62767 Website: http://insurance.illinois.gov/	Toll-free: 1-877-527-9431 TTY/TDD: 1-866-323-5321
Illinois		
State Medical Assistance Office	Illinois Department of Healthcare and Family Services 401 South Clinton Street, Chicago, IL 60607 Website: http://www2.illinois.gov/hfs/Pages/default.aspx	Toll-free: 1-800-226-0768 Local: 1-217-782-4977 TTY/TDD: 1-800-447-6404
Indiana		
AIDS Drug Assistance Program (ADAP)	Indiana State Department of Health AIDS Drug Assistance Plan 2 N. Meridian St., Indianapolis, IN 46204 Website: http://www.in.gov/isdh/17740.htm	Toll-free: 1-866-588-4948 Local: 1-317-233-7450 TTY/TDD: 711
Indiana		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Indiana		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 311 West Washington Street, Indianapolis, IN 46204 Website: http://www.medicare.in.gov	Toll-free: 1-800-452-4800 Local: 1-765-608-2318 TTY/TDD: 1-317-234-9634

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Indiana		
State Department of Insurance	Indiana Department of Insurance 311 W. Washington St., Suite 103 Indianapolis, IN 46204 Fax: 1-317-232-5251 Website: http://www.in.gov/idoi	Toll-free: 1-800-622-4461 Local: 1-317-232-2385 TTY/TDD: 711
Indiana		
State Medical Assistance Office	Indiana Family and Social Services Administration FSSA Document Center, P.O. Box 1810 Marian, IN 46952 Website: http://www.in.gov/fssa/	Toll-free: 1-800-403-0864 Local: 1-317-713-9627 TTY/TDD: 1-800-962-8408
Indiana		
State Pharmaceutical Assistance Program	HoosierRx PO Box 6224, Indianapolis, IN 46206 Fax: 1-317-234-3709 Website: http://at.in.gov/hoosierx	Toll-free: 1-866-267-4679 Local: 1-317-234-1381 TTY/TDD: 711
Iowa		
AIDS Drug Assistance Program (ADAP)	Iowa Dept of Public Health - Bureau of HIV, STD and Hepatitis: ADAP Coordinator 321 East 12th Street, Des Moines, IA 50319 Fax: 1-515-281-4570 Website: http://idph.iowa.gov/hivstdhiv/hiv/support	Local: 1-515-281-0926 TTY/TDD: 711
Iowa		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Iowa		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIIP) Two Ruan Center 601 Locust St. 4th floor, Two Ruan Center Des Moines, IA 50309 Website: http://www.shiip.state.ia.us/	Toll-free: 1-800-351-4664 TTY/TDD: 1-800-735-2942

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Iowa		
State Department of Insurance	Iowa Insurance Division 601 Locust St. 4th Floor, Two Ruan Center Des Moines, IA 50309 Website: http://www.iid.state.ia.us	Toll-free: 1-877-955-1212 In State Only Local: 1-515-281-5705 Des Moines TTY/TDD: 711
Iowa		
State Medical Assistance Office	Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME) P.O. Box 36510, Des Moines, IA 50315 Fax: 1-515-725-1351 Website: http://dhs.iowa.gov/	Toll-free: 1-800-338-8366 Local: 1-515-256-4606 TTY/TDD: 711
Kansas		
AIDS Drug Assistance Program (ADAP)	Kansas Dept of Health and Environment-STI/HIV Section: AIDS Drug Assistance Program Coordinator 1000 SW Jackson, Suite 210 Topeka, KS 66612 Fax: 1-785-559-4225 Website: http://www.kdheks.gov/sti_hiv/ryan_white_care.htm	Local: 1-785-296-6174 TTY/TDD: 711
Kansas		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Kansas		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Avenue, Topeka, KS 66603 Website: http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick	Toll-free: 1-800-860-5260 Local: 1-785-291-3357 TTY/TDD: 1-785-291-3167

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Kansas		
State Department of Insurance	Kansas Insurance Department 420 SW 9th Street, Topeka, KS 66612 Fax: 1-785-296-5806 Appeals Fax: Website: http://www.ksinsurance.org/	Toll-free: 1-800-432-2484 In State Only Local: 1-785-296-7829 TTY/TDD: 711
Kansas		
State Medical Assistance Office	KanCare-Kansas Medicaid Program PO Box 3599, Topeka, KS 66601 Website: http://www.kancare.ks.gov/	Toll-free: 1-800-792-4884 Local: 1-785-296-3981 TTY/TDD: 711
Kentucky		
AIDS Drug Assistance Program (ADAP)	Kentucky Department for Public Health - Cabinet for Health & Family Services, Division of Epidemiology: KADAP Coordinator 275 E. Main St., Mail Stop HS2E-C#980 Frankfort, KY 40621 Fax: 1-877-353-9380 Website: http://chfs.ky.gov/dph/epi/hiv aids/services.htm	Toll-free: 1-866-510-0005 Local: 1-502-564-6539 ext. 4286 TTY/TDD: 711
Kentucky		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Kentucky		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 275 E. Main St., 3E-E, Frankfort, KY 40621 Website: http://www.chfs.ky.gov/dail/ship.htm	Toll-free: 1-877-293-7447 Local: 1-502-564-6930 TTY/TDD: 711
Kentucky		
State Department of Insurance	Kentucky Department of Insurance P.O. Box 517, Frankfort, KY 40602 Website: http://insurance.ky.gov/	Toll-free: 1-800-595-6053 Local: 1-502-564-3630 TTY/TDD: 1-800-648-6056

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Kentucky		
State Medical Assistance Office	Kentucky Cabinet for Health and Family Services - Department for Medicaid Services 275 E. Main St., Frankfort, KY 40621 Website: http://www.chfs.ky.gov/dms	Toll-free: 1-800-635-2570 Local: 1-502-564-4321 TTY/TDD: 711
Louisiana		
AIDS Drug Assistance Program (ADAP)	Louisiana Health Access Program (LA HAP) 1450 Poydras Street, Ste. 2136 New Orleans, LA 70112 Fax: 1-504-568-3157 Website: http://www.lahap.org	Local: 1-504-568-7474 TTY/TDD: 711
Louisiana		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Louisiana		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIIP) P.O. Box 94214 Baton Rouge, LA 70804 Website: http://www.lidi.la.gov/SHIIP	Toll-free: 1-800-259-5300 Local: 1-225-342-5301 TTY/TDD: 1-800-325-0778
Louisiana		
State Department of Insurance	Louisiana Department of Insurance 1702 N. Third Street Baton Rouge, LA 70802 Website: http://www.lidi.state.la.us/	Toll-free: 1-800-259-5300 Local: 1-225-342-5900 TTY/TDD: 711
Louisiana		
State Medical Assistance Office	Louisiana Department of Health - Louisiana Medicaid PO Box 91278 Baton Rouge, LA 70821 Fax: 1-877-523-2987 Website: http://ldh.louisiana.gov/index.cfm/subhome/1	Toll-free: 1-888-342-6207 TTY/TDD: 1-800-220-5404

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Maine		
AIDS Drug Assistance Program (ADAP)	Maine AIDS Drug Assistance Program 286 Water St., 11 State House Station, Augusta, ME 04333 Fax: 1-207-287-3498 Website: http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml	Local: 1-207-287-3747 TTY/TDD: 711
Maine		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
Maine		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 41 Anthony Ave., Augusta, ME 04333 Website: http://www.maine.gov/dhhs/oads/index.html	Toll-free: 1-800-262-2232 TTY/TDD: 711
Maine		
State Department of Insurance	Department of Professional and Financial Regulation Maine Bureau of Insurance 34 State House Station, Augusta, ME 04333 Fax: 1-207-624-8599 Website: http://www.maine.gov/insurance	Toll-free: 1-800-300-5000 Local: 1-207-624-8475 TTY/TDD: 711
Maine		
State Medical Assistance Office	Department of Health and Human Services - Office of Family Independence, MaineCare (Medicaid) 114 Corn Shop lane, Farmington, ME 04938 Fax: 1-207-778-8429 Website: http://www.maine.gov/dhhs/oms/member/	Toll-free: 1-800-977-6740 TTY/TDD: 711

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Maine		
State Pharmaceutical Assistance Program	Maine Rx Plus / Maine Low Cost Drugs for the Elderly or Disabled Program 242 State St., Augusta, ME 04333 Fax: 1-207-287-8601 Website: http://www.maine.gov/dhhs/oads/	Toll-free: 1-866-796-2463 TTY/TDD: 711
Maryland		
AIDS Drug Assistance Program (ADAP)	Maryland Department of Health and Mental Hygiene - AIDS Administration and Client Services: Deputy Chief for Client Services 500 N. Calvert Street, 5th floor Baltimore, MD 21202 Fax: 1-410-333-2608 Website: http://phpa.dhmm.maryland.gov/OIDPCS/CHCS/pages/madap.aspx	Toll-free: 1-800-205-6308 Local: 1-410-767-6535 TTY/TDD: 711
Maryland		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Maryland		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 301 West Preston Street, Suite 1007 Baltimore, MD 21201 Fax: 1-410-333-7943 Website: http://www.aging.maryland.gov	Toll-free: 1-800-243-3425 Local: 1-410-767-1100 TTY/TDD: 711
Maryland		
State Department of Insurance	Maryland Insurance Administration 200 St. Paul Place, Suite 2700 Baltimore, MD 21202 Fax: 1-410-468-2270 Website: http://www.mdinsurance.state.md.us/	Toll-free: 1-800-492-6116 Local: 1-410-468-2000 TTY/TDD: 1-800-735-2258

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Maryland		
State Medical Assistance Office	Maryland Department of Health 201 West Preston Street, Baltimore, MD 21201 Website: https://mmcp.dhmh.maryland.gov/SitePages/Home.aspx	Toll-free: 1-877-463-3464 Local: 1-410-767-6500 TTY/TDD: 711
Maryland		
State Pharmaceutical Assistance Program	Maryland Senior Prescription Drug Assistance Program (SPDAP) 628 Hebron Avenue, Suite 100 Glastonbury, CT 06033 Fax: 1-800-847-8217 Website: http://marylandspdap.com	Toll-free: 1-800-551-5995 TTY/TDD: 1-800-877-5156
Massachusetts		
AIDS Drug Assistance Program (ADAP)	Office of HIV/AIDS - HDAP: Coordinator 38 Chauncy St., Suite 500 Boston, MA 02111 Fax: 1-617-502-1703 Website: http://www.mass.gov/eohhs/gov/departments/dph/programs/id/hiv-aids/	Toll-free: 1-800-228-2714 Local: 1-617-502-1700 TTY/TDD: 711
Massachusetts		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
Massachusetts		
SHIP -- State Health Insurance Assistance Program	Serving Health Information Needs of Elders (SHINE) One Ashburton Place, 5th Floor Boston, MA 02108 Fax: 1-617-727-9368 Website: http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html	Toll-free: 1-800-243-4636 Local: 1-617-727-7750 TTY/TDD: 711

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Massachusetts		
State Department of Insurance	Office of Consumer Affairs and Business Regulation Massachusetts Division of Insurance 1000 Washington St, Suite 810 Boston, MA 02118 Website: http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/	Toll-free: 1-877-563-4467 Local: 1-617-521-7794 TTY/TDD: 711
Massachusetts		
State Medical Assistance Office	Office of Health and Human Services of Massachusetts One Ashburton Place, 11th Floor Boston, MA 02108 Website: http://www.mass.gov/masshealth	Toll-free: 1-800-841-2900 Local: 1-617-847-3700 TTY/TDD: 711
Massachusetts		
State Pharmaceutical Assistance Program	Massachusetts Prescription Advantage P.O. Box 15153, Worcester, MA 01615 Website: http://www.mass.gov/elders/healthcare/prescription-advantage/prescription-advantage-overview.html	Toll-free: 1-800-243-4636 TTY/TDD: 711
Michigan		
AIDS Drug Assistance Program (ADAP)	Michigan Department of Community Health: ADAP Coordinator 109 Michigan Avenue, 9th Floor Lansing, MI 48913 Fax: 1-517-335-7723 Website: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_46000_61638---,00.html	Toll-free: 1-888-826-6565 TTY/TDD: 711
Michigan		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776

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Michigan		
SHIP -- State Health Insurance Assistance Program	MMAP, Inc. P.O. Box 30676, Lansing, MI 48909 Fax: 1-517-373-4092 Website: http://mmapinc.org	Toll-free: 1-800-803-7174 Local: 1-517-373-7692 TTY/TDD: 711
Michigan		
State Department of Insurance	Department of Insurance and Financial Services P.O. Box 30220, Lansing, MI 48909 Fax: 1-517-284-8837 Website: http://www.michigan.gov/difs	Toll-free: 1-877-999-6442 Local: 1-517-284-8800 TTY/TDD: 711
Michigan		
State Medical Assistance Office	Michigan Department Community Health 201 Townsend Street, Lansing, MI 48913 Website: http://www.michigan.gov/mdch	Toll-free: 1-800-642-3195 Local: 1-517-373-3740 TTY/TDD: 711
Minnesota		
AIDS Drug Assistance Program (ADAP)	Minnesota Department of Human Services - HIV/AIDS Unit: Program Administrator P.O. Box 64972, St. Paul, MN 55164 Fax: 1-651-431-7414 Website: http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp	Toll-free: 1-800-657-3761 Local: 1-651-431-2414 TTY/TDD: 711
Minnesota		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Minnesota		
SHIP -- State Health Insurance Assistance Program	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 2365 N McKnight Rd., St. Paul, MN 55109 Website: http://www.mnaging.org/	Toll-free: 1-800-333-2433 TTY/TDD: 711

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Minnesota		
State Department of Insurance	Department of Commerce of Minnesota 85 7th Place East, Suite 280 St Paul, MN 55101 Fax: 1-651-539-1547 Website: http://www.commerce.state.mn.us/	Toll-free: 1-800-657-3602 Local: 1-651-539-1500 TTY/TDD: 711
Minnesota		
State Medical Assistance Office	Department of Human Services of Minnesota - MinnesotaCare PO Box 64838, St Paul, MN 55164 Website: http://mn.gov/dhs/	Toll-free: 1-800-657-3672 Local: 1-651-431-2801 TTY/TDD: 711
Mississippi		
AIDS Drug Assistance Program (ADAP)	Mississippi Department of Health - Care and Services Division, Office of STD/HIV: ADAP Director 570 East Woodrow Wilson, Jackson, MS 39215 Fax: 1-601-362-4782 Website: http://msdh.ms.gov/msdhsite/_static/14,13047,150.html	Toll-free: 1-888-343-7373 Local: 1-601-576-7642 TTY/TDD: 711
Mississippi		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Mississippi		
SHIP -- State Health Insurance Assistance Program	MS State Health Insurance Assistance Program (SHIP) 750 North State Street, Jackson, MS 39202 Fax: 1-601-359-9664 Website: http://www.mdhs.state.ms.us/programs-and-services-for-seniors/state-health-insurance-assistance-program/	Toll-free: 1-844-822-4622 Local: 1-601-359-4366 TTY/TDD: 711
Mississippi		
State Department of Insurance	Mississippi Insurance Department P.O. Box 79, Jackson, MS 39205 Fax: 1-601-359-1077 Website: http://www.mid.ms.gov/	Toll-free: 1-800-562-2957 Local: 1-601-359-3569 TTY/TDD: 711
Mississippi		
State Medical Assistance Office	Mississippi Division of Medicaid 550 High Street, Suite 1000 Jackson, MS 39201	Toll-free: 1-800-421-2408 Local: 1-601-359-6050 TTY/TDD: 711

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	Fax: 1-601-359-6294 Website: https://www.medicaid.ms.gov/	
Missouri		
AIDS Drug Assistance Program (ADAP)	Missouri Department of Health and Senior Services - Prevention and Care Programs, Section of Communicable Disease Prevention: HIV Care Coordinator 930 Wildwood Drive, Jefferson City, MO 65109 Fax: 1-573-751-6447 Website: http://health.mo.gov/living/healthcondiseases/communicable/hiv aids/casemgmt.php	Toll-free: 1-866-628-9891 Local: 1-573-751-6439 TTY/TDD: 711
Missouri		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Missouri		
SHIP -- State Health Insurance Assistance Program	CLAIM 200 N. Keene St., Suite 101 Columbia, MO 65201 Website: http://www.missouricclaim.org	Toll-free: 1-800-390-3330 Local: 1-573-817-8320 TTY/TDD: 711
Missouri		
State Department of Insurance	Missouri Department of Insurance PO Box 690, Jefferson City, MO 65102 Fax: 1-573-526-4898 Website: http://www.insurance.mo.gov	Toll-free: 1-800-726-7390 Local: 1-573-751-4126 TTY/TDD: 711
Missouri		
State Medical Assistance Office	Missouri Department of Social Services MO HealthNet Division 615 Howerton Court, P.O. Box 6500 Jefferson City, MO 65102 Fax: 1-573-751-6564 Website: http://www.dss.mo.gov/mhd/	Toll-free: 1-800-392-2161 Local: 1-573-751-3425 TTY/TDD: 711

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Missouri		
State Pharmaceutical Assistance Program	Missouri Rx Plan 615 Howerton Court P.O. Box 6500, Jefferson City, MO 65102 Website: http://morx.mo.gov/	Toll-free: 1-800-375-1406 TTY/TDD: 711
Montana		
AIDS Drug Assistance Program (ADAP)	Montana Dept. of Public Health and Human Services - STD/HIV Section: Manager 1400 Broadway, Cogswell Building, Room C211 Helena, MT 59620 Fax: 1-406-444-6842 Website: http://dphhs.mt.gov/publichealth/hivstd.aspx	Local: 1-406-444-4744 TTY/TDD: 711
Montana		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Montana		
SHIP -- State Health Insurance Assistance Program	Montana State Health Insurance Assistance Program (SHIP) 2030 - 11th Ave, Helena, MT 59604 Website: http://dphhs.mt.gov/SLTC/aging/SHIP	Toll-free: 1-800-551-3191 TTY/TDD: 711
Montana		
State Department of Insurance	Commissioner of Securities and Insurance - Consumer Service Division 840 Helena Ave., Helena, MT 59601 Fax: 1-406-444-3497 Website: http://csimt.gov/your-insurance/health/	Toll-free: 1-800-332-6148 Local: 1-406-444-2040 TTY/TDD: 1-406-444-3426
Montana		
State Medical Assistance Office	Montana Medicaid 2030 11th Avenue, Helena, MT 59601 Website: http://www.dphhs.mt.gov	Toll-free: 1-800-362-8312 TTY/TDD: 711

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Montana		
State Pharmaceutical Assistance Program	Montana Big Sky Rx Program P.O. Box 202915, Helena, MT 59620 Fax: 1-406-444-3846 Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx	Toll-free: 1-866-369-1233 Local: 1-406-444-1233 TTY/TDD: 711
Nebraska		
AIDS Drug Assistance Program (ADAP)	Nebraska Department of Health and Human Services - Infectious Diseases Prevention: ADAP Coordinator 988106 Nebraska Medical Center, Omaha, NE 68198 Fax: 1-402-553-5527 Website: http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_w_hite.aspx	Toll-free: 1-866-632-2437 Local: 1-402-559-4673 TTY/TDD: 711
Nebraska		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Nebraska		
SHIP -- State Health Insurance Assistance Program	Nebraska Senior Health Insurance Information Program (SHIIP) 941 O Street Suite 400 , P.O. Box 82089, Lincoln, NE 68508 Website: http://www.doi.nebraska.gov/shiip/	Toll-free: 1-800-234-7119 Local: 1-402-471-2201 TTY/TDD: 711
Nebraska		
State Department of Insurance	Nebraska Department of Insurance 941 O Street Suite 400 , P.O. Box 82089, Lincoln, NE 68501 Website: http://www.doi.nebraska.gov/	Toll-free: 1-877-564-7323 In State Only Local: 1-402-471-2201 TTY/TDD: 1-800-833-7352
Nebraska		
State Medical Assistance Office	Nebraska Department of Health and Human Services System 301 Centennial Mall South, Lincoln, NE 68509 Website: www.Accessnebraska.ne.gov	Toll-free: 1-855-632-7633 Local: 1-402-471-3121 TTY/TDD: 711
Nevada		
AIDS Drug Assistance Program (ADAP)	Department of Human Resources - Communicable Disease Program, Bureau of Community Health: ADAP Coordinator	Toll-free: 1-877-385-2345 Local: 1-775-284-8989 TTY/TDD: 711

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	4001 S. Virginia St., Suite F. Reno, NV 89502 Fax: 1-702-489-3600 Website: http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home	
Nevada		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
Nevada		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 3416 Goni Road, Suite D-132 Carson City, NV 89706 Website: http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	Toll-free: 1-800-307-4444 Local: 1-702-486-3478 TTY/TDD: 711
Nevada		
State Department of Insurance	Nevada Department of Business and Industry - Division of Insurance 1818 E. College Pkwy, Ste. 103 Carson City, NV 89706 Fax: 1-775-687-0787 Website: http://doi.state.nv.us/	Toll-free: 1-888-872-3234 Local: 1-775-687-0700 TTY/TDD: 711
Nevada		
State Medical Assistance Office	Nevada Department of Health and Human Services 1210 S. Valley View, Suite 104 Las Vegas, NV 89102 Website: http://dhhs.nv.gov/	Toll-free: 1-800-992-0900 Local: 1-702-668-4200 TTY/TDD: 711

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Nevada		
State Pharmaceutical Assistance Program	Nevada Senior Rx Program - Department of Health and Human Services 3416 Goni Road, Suite D-132 Carson City, NV 89706 Fax: 1-775-687-0576 Website: http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/	Toll-free: 1-866-303-6323 Local: 1-775-687-4210 TTY/TDD: 711
New Hampshire		
AIDS Drug Assistance Program (ADAP)	DHHS New Hampshire CARE Program 29 Hazen Drive, Concord, NH 03301 Fax: 1-603-271-4934 Website: http://www.dhhs.nh.gov/dphs/bchs/std/care.htm	Toll-free: 1-800-852-3345 ext 4502 (In State Only) Local: 1-800-735-2964 TTY/TDD: 711
New Hampshire		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
New Hampshire		
SHIP -- State Health Insurance Assistance Program	NH SHIP - ServiceLink Resource Center 67 Water St., Suite 105 Laconia, NH 03246 Website: www.servicelink.nh.gov	Toll-free: 1-866-634-9412 TTY/TDD: 711
New Hampshire		
State Department of Insurance	New Hampshire Insurance Department 21 South Fruit Street, Suite 14 Concord, NH 03301 Fax: 1-603-271-1406 Website: http://www.nh.gov/insurance	Toll-free: 1-800-852-3416 Local: 1-603-271-2261 TTY/TDD: 1-800-735-2964
New Hampshire		
State Medical Assistance Office	NH Medicaid 129 Pleasant St., Main Building Concord, NH 03301 Fax: 1-603-271-4230 Website: https://www.dhhs.nh.gov/ombp/medicaid/index.htm	Toll-free: 1-800-852-3345 Ext. 4344 Local: 1-603-271-4344 TTY/TDD: 1-800-735-2964
New Jersey		
AIDS Drug Assistance Program (ADAP)	New Jersey Department of Health and Senior Services - Division of HIV/AIDS Services: Coordinator Primary and Preventive Health	Toll-free: 1-800-353-3232 Local: 1-609-984-6328 TTY/TDD: 711

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	Services PO Box 722, Trenton, NJ 08625 Fax: 1-609-588-7037 Website: http://www.state.nj.us/health/	
New Jersey		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
New Jersey		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) PO Box 715, Trenton, NJ 08625 Website: http://www.state.nj.us/humanservices/doas/services/ship/	Toll-free: 1-800-792-8820 TTY/TDD: 711
New Jersey		
State Department of Insurance	State of New Jersey -Department of Banking and Insurance 20 West State Street, PO Box 325 Trenton, NJ 08625 Fax: 1-609-984-5273 Website: http://www.state.nj.us/dobi/index.html	Toll-free: 1-800-446-7467 Local: 1-609-292-7272 TTY/TDD: 711
New Jersey		
State Medical Assistance Office	Division of Medical Assistance and Health Services PO Box 712, Trenton, NJ 08625 Website: http://www.state.nj.us/humanservices/dmahs	Toll-free: 1-800-356-1561 TTY/TDD: 711

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New Jersey		
State Pharmaceutical Assistance Program	New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD) P.O. Box 715, PAAD-HAAAD Trenton, NJ 08625 Website: http://www.state.nj.us/humanservices/doas/services/paad/	Toll-free: 1-800-792-9745 TTY/TDD: 711
New Jersey		
State Pharmaceutical Assistance Program	New Jersey Senior Gold Prescription Discount Program P.O. Box 715, PAAD-HAAAD Trenton, NJ 08625 Website: http://www.state.nj.us/humanservices/doas/home/seniorgolddetail.html	Toll-free: 1-800-792-9745 TTY/TDD: 711
New Mexico		
AIDS Drug Assistance Program (ADAP)	New Mexico Department of Health - Infectious Disease Bureau: ADAP Coordinator 1190 St. Francis Drive, Suite S1200 Santa Fe, NM 87502 Website: http://nmhivguide.org/search_detail.php?id=75	Local: 1-505-827-2435 TTY/TDD: 711
New Mexico		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
New Mexico		
SHIP -- State Health Insurance Assistance Program	Benefits Counseling Program P.O.Box 27118, Santa Fe, NM 87502 Website: http://www.nmaging.state.nm.us/	Toll-free: 1-800-432-2080 Local: 1-505-476-4846 TTY/TDD: 711
New Mexico		
State Department of Insurance	Office of Superintendent of Insurance 1120 Paseo De Peralta, 4th Floor Santa Fe, NM 87501 Website: http://www.osi.state.nm.us/	Toll-free: 1-855-427-5674 Local: 1-505-827-4601 TTY/TDD: 711

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New Mexico		
State Medical Assistance Office	New Mexico Medicaid P.O. Box 2348, Santa Fe, NM 87504 Website: http://www.hsd.state.nm.us/	Toll-free: 1-888-997-2583 Local: 1-505-827-3100 TTY/TDD: 711
New York		
AIDS Drug Assistance Program (ADAP)	AIDS Institute--Department of Health - HIV Uninsured Care Programs: Director PO Box 2052, Albany, NY 12220 Fax: 1-518-459-2749 Website: https://www.health.ny.gov/diseases/aids/general/resources/adap/	Toll-free: 1-800-542-2437 Local: 1-518-459-1641 TTY/TDD: 711
New York		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
New York		
SHIP -- State Health Insurance Assistance Program	Health Insurance Information Counseling and Assistance Program (HIICAP) 10 Cayuga Plaza, Cohoes, NY 12206 Website: http://www.aging.ny.gov/HealthBenefits/Index.cfm	Toll-free: 1-800-701-0501 Local: 1-518-447-7177 TTY/TDD: 711
New York		
State Department of Insurance	New York State Department of Financial Services- Consumer Assistance Unit One Commerce Plaza, Albany, NY 12257 Fax: 1-212- 480-6282 Website: http://www.dfs.ny.gov/insurance/dfs_insurance.htm	Toll-free: 1-800-342-3736 Local: 1-212-480-6400 TTY/TDD: 711
New York		
State Medical Assistance Office	New York State Department of Health Corning Tower, Empire State Plaza Albany, NY 12237 Website: http://www.health.ny.gov/health_care/medicaid/index.htm	Toll-free: 1-800-541-2831 TTY/TDD: 711
New York		
State Pharmaceutical Assistance Program	New York State EPIC (Senior Pharmaceutical Insurance Coverage) P.O. Box 15018,	Toll-free: 1-800-332-3742 TTY/TDD: 1-800-290-9138

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	Albany, NY 12212 Fax: 1-518-452-3576 Website: http://www.health.ny.gov/health_care/epic/	
North Carolina		
AIDS Drug Assistance Program (ADAP)	North Carolina Department of Health and Human Services - Division of Public Health, Communicable Disease Branch 1902 Mail Service Center Raleigh, NC 27699 Fax: 1-919-715-5221 Website: http://epi.publichealth.nc.gov/cd/hiv/adap.html	Toll-free: 1-877-466-2232 In State Only Local: 1-919-733-9161 TTY/TDD: 711
North Carolina		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
North Carolina		
SHIP -- State Health Insurance Assistance Program	Seniors Health Insurance Information Program (SHIIP) 1201 Mail Service Center, Raleigh, NC 27699 Fax: 1-919-807-6901 Website: http://www.ncdoi.com/SHIIP/Default.aspx	Toll-free: 1-855-408-1212 Local: 1-919-807-6900 TTY/TDD: 711
North Carolina		
State Department of Insurance	North Carolina Department of Insurance-Services for Consumers 1201 Mail Service Center, Raleigh, NC 27669 Fax: 1-919-733-6495 Website: http://www.ncdoi.com	Toll-free: 1-855-408-1212 Local: 1-919-807-6000 TTY/TDD: 711

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North Carolina		
State Medical Assistance Office	North Carolina Department of Health and Human Services - Medicaid 2501 Mail Service Center, Raleigh, NC 27699 Fax: 1-919-224-1072 Website: http://dma.ncdhhs.gov/	Toll-free: 1-888-245-0179 Local: 1-919-813-5550 TTY/TDD: 711
North Carolina		
State Pharmaceutical Assistance Program	North Carolina Department of Health and Human Services - Division of Public Health, SPAP 1902 Mail Service Center, Raleigh, NC 27699 Website: http://epi.publichealth.nc.gov/cd/hiv/adap.html	Toll-free: 1-877-466-2232 In State Only Local: 1-919-733-9161 TTY/TDD: 711
North Dakota		
AIDS Drug Assistance Program (ADAP)	North Dakota Department of Health: AIDS Drug Assistance Program (ADAP) 2635 East Main Avenue, Bismarck, ND 58506 Fax: 1-701-328-0356 Website: http://www.ndhealth.gov/HIV	Toll-free: 1-800-472-2180 In state only Local: 1-701-328-2378 TTY/TDD: 1-800-366-6889
North Dakota		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
North Dakota		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Counseling (SHIC) 600 E. Boulevard Ave., 5th Floor, Dept 401 Bismarck, ND 58505 Fax: 1-701-328-9610 Website: http://www.nd.gov/ndins/shic/	Toll-free: 1-888-575-6611 Local: 1-701-328-2440 TTY/TDD: 1-800-247-0560
North Dakota		
State Department of Insurance	North Dakota Insurance Department 600 E. Boulevard Ave., 5th Floor, Dept 401 Bismarck, ND 58505 Fax: 1-701-328-4880 Website: http://www.state.nd.us/ndins/	Toll-free: 1-800-247-0560 Local: 1-701-328-2440 TTY/TDD: 1-800-247-0560

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North Dakota		
State Medical Assistance Office	North Dakota, Department of Human Services - North Dakota Medicaid 600 E Boulevard Ave, 3rd Floor, Dept 325 Bismarck, ND 58505 Fax: 1-701-328-1544 Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	Toll-free: 1-800-755-2604 Local: 1-701-328-7068 TTY/TDD: 711
Ohio		
AIDS Drug Assistance Program (ADAP)	Ohio Department of Health - HIV Care Services-Ohio Department of Health: OHDAP Administrator 246 N. High Street, 6th Floor Columbus, OH 43215 Fax: 1-614-728-4622 Website: http://www.odh.ohio.gov/odhPrograms/hastpac/hivcare/aids1.aspx	Toll-free: 1-800-777-4775 Local: 1-614-466-6374 TTY/TDD: 711
Ohio		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Ohio		
SHIP -- State Health Insurance Assistance Program	Ohio Senior Health Insurance Information Program (OSHIIP) 50 W. Town Street, Third Floor - Suite 300 Columbus, OH 43215 Fax: 1-614-752-0740 Website: http://www.insurance.ohio.gov/Consumer/Pages/ConsumerTab2.aspx	Toll-free: 1-800-686-1578 TTY/TDD: 711
Ohio		
State Department of Insurance	Ohio Department of Insurance 50 W. Town Street, Third Floor - Suite 300 Columbus, OH 43215 Fax: 1-614-644-3744 Website: http://www.insurance.ohio.gov	Toll-free: 1-800-686-1526 Local: 1-614-644-2658 TTY/TDD: 711

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Ohio		
State Medical Assistance Office	Ohio Department of Medicaid 50 West Town Street, Suite 400 Columbus, OH 43215 Website: http://medicaid.ohio.gov/	Toll-free: 1-800-324-8680 TTY/TDD: 711
Oklahoma		
AIDS Drug Assistance Program (ADAP)	Oklahoma State Department of Health - HIV/STD Service: HDAP/ADAP Programs Manager 1000 N.E. 10th Street, Oklahoma City, OK 73117 Website: http://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/	Local: 1-405-271-4636 TTY/TDD: 711
Oklahoma		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Oklahoma		
SHIP -- State Health Insurance Assistance Program	Oklahoma Medicare Assistance Program (MAP) Five Corporate Plaza 3625 NW 56th St., Suite 100, Suite 100 Oklahoma City, OK 73112 Fax: 1-405-522-4492 Website: http://www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html	Toll-free: 1-800-763-2828 In State Only Local: 1-405-521-6628 TTY/TDD: 1-877-588-6025
Oklahoma		
State Department of Insurance	Oklahoma Insurance Department - Consumer Service Division Five Corporate Plaza, 3625 NW 56th St., Suite 100 Oklahoma City, OK 73112 Fax: 1-405-521-6652 Website: https://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html	Toll-free: 1-800-522-0071 In State Only Local: 1-405-521-2828 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

Oklahoma		
State Medical Assistance Office	Oklahoma Health Care Authority (SoonerCare) PO Box 548804, Oklahoma City, OK 73154 Website: www.mysooner.org	Toll-free: 1-800-987-7767 TTY/TDD: 711
Oregon		
AIDS Drug Assistance Program (ADAP)	Oregon Health Authority, Public Health - CAREAssist P O Box 14450, Portland, OR 97293-0450 Fax: 1-971-673-0177 Website: https://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	Toll-free: 1-800-805-2313 Local: 1-971-673-0144 TTY/TDD: 1-971-673-0372
Oregon		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
Oregon		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St., P.O. Box 14480 Salem, OR 97309 Fax: 1-503-947-7092 Website: http://oregonshiba.org	Toll-free: 1-800-722-4134 Local: 1-503-947-7979 TTY/TDD: 1-800-735-2900
Oregon		
State Department of Insurance	Oregon Department of Consumer and Business Services Division of Financial Regulation 350 Winter St. NE Room 410 (4th Floor), P.O. Box 14480 Salem, OR 97309 Fax: 1-503-947-7092 Website: http://www.insurance.oregon.gov	Toll-free: 1-888-877-4894 Local: 1-503-947-7984 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

Oregon		
State Medical Assistance Office	Oregon Health Plan 500 Summer St. NE, Salem, OR 97301 Fax: 1-503-378-5628 Website: http://www.oregon.gov/oha/healthplan/pages/index.aspx	Toll-free: 1-800-699-9075 Local: 1-503-945-5772 TTY/TDD: 711
Pennsylvania		
AIDS Drug Assistance Program (ADAP)	Department of Health - Division of Pharmacy Program Operations, Bureau of Fee for Service Programs: SPBP Administrator P.O. Box 8808, Harrisburg, PA 17105 Fax: 1-888-656-0372 Website: http://www.health.pa.gov/spbp	Toll-free: 1-800-922-9384 TTY/TDD: 711
Pennsylvania		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
Pennsylvania		
SHIP -- State Health Insurance Assistance Program	APPRISE 555 Walnut Street, 5th Floor Harrisburg, PA 17101 Website: http://www.aging.pa.gov/aging-services/insurance	Toll-free: 1-800-783-7067 Local: 1-717-783-1550 TTY/TDD: 711
Pennsylvania		
State Department of Insurance	Pennsylvania Insurance Department 1326 Strawberry Square, Harrisburg, PA 17120 Fax: 1-717-787-8585 Website: http://www.insurance.pa.gov	Toll-free: 1-877-881-6388 Local: 1-717-787-2317 TTY/TDD: 711
Pennsylvania		
State Medical Assistance Office	Department of Human Services P.O. Box 2675, Harrisburg, PA 17105 Website: http://www.dhs.pa.gov/citizens/healthcaremedicalassistance	Toll-free: 1-800-692-7462 TTY/TDD: 711
Pennsylvania		
State Pharmaceutical Assistance Program	Pharmaceutical Assistance Contract for the Elderly (PACE) - (PACENET) P.O. Box 8806,	Toll-free: 1-800-225-7223 Local: 1-717-651-3600 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

	Harrisburg, PA 17105 Fax: 1-888-656-0372 Website: http://www.aging.pa.gov/prescriptions	
Rhode Island		
AIDS Drug Assistance Program (ADAP)	Rhode Island Department Health - Office of HIV/AIDS and Viral Hepatitis: Assistant ADAP Coordinator 74 West Road, Suite 60 Cranston, RI 02920 Fax: 1-401-462-3297 Website: http://www.health.ri.gov/diseases/hivaids/about/stayinghealthy/	Local: 1-401-462-3294 TTY/TDD: 711
Rhode Island		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
Rhode Island		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Program (SHIP) 74 West Road, Hazard Bldg Cranston, RI 02920 Website: http://www.dea.ri.gov/insurance/	Local: 1-401-462-0510 TTY/TDD: 711
Rhode Island		
State Department of Insurance	State of Rhode Island Department of Business Regulation - Division of Insurance 1511 Pontiac Avenue, Bldg. #69-2 Cranston, RI 02920 Fax: 1-401-462-9602 Website: http://www.dbr.state.ri.us	Local: 1-401-462-9520 TTY/TDD: 711
Rhode Island		
State Medical Assistance Office	Rhode Island Department of Human Services 206 Elmwood Avenue, Providence, RI 02907 Website: http://www.dhs.ri.gov	Toll-free: 1-855-697-4347 Local: 1-401-462-5300 TTY/TDD: 1-401-462-3363
Rhode Island		
State Pharmaceutical Assistance Program	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) - Attention RIPAE Rhode Island Department of Elderly Affairs 25 Howard Avenue, Bldg 57 Cranston, RI 02920 Website: http://www.dea.state.ri.us/programs/prescription_assist.php	Local: 1-401-462-3000 TTY/TDD: 1-401-462-0740
South Carolina		
AIDS Drug	South Carolina Department of Health & Env.	Toll-free: 1-800-856-9954

Addendum A: Important Contact Information for State Agencies

Assistance Program (ADAP)	Control - HIV/AIDS Division: ADAP Director P.O. Box 101106, SC Drug Assistance, 3rd Floor, Mills-Jarrett Bldg. Columbia, SC 29211 Fax: 1-803-898-0475 Website: http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan/	Local: 1-803-898-0749 TTY/TDD: 711
South Carolina		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
South Carolina		
SHIP -- State Health Insurance Assistance Program	(I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais Street, Suite 350 Columbia, SC 29201 Website: http://aging.sc.gov/programs/medicare/Pages/default.aspx	Toll-free: 1-800-868-9095 Local: 1-803-734-9900 TTY/TDD: 711
South Carolina		
State Department of Insurance	South Carolina Department of Insurance P.O. Box 100105, Columbia, SC 29202 Fax: 1-803-737-6231 Website: http://www.doi.sc.gov	Toll-free: 1-800-768-3467 Local: 1-803-737-6160 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

South Carolina		
State Medical Assistance Office	Healthy Connection South Carolina Medicaid Program P. O. Box 8206, Columbia, SC 29202 Website: http://www.scdhhs.gov/	Toll-free: 1-888-549-0820 Local: 1-803-898-2500 TTY/TDD: 711
South Dakota		
AIDS Drug Assistance Program (ADAP)	Health Department - Office of Disease Prevention; HIV Surveillance, Ryan White CARE Programs: Ryan White CARE/ADAP Program Manager 615 East 4th St., Pierre, SD 57501 Fax: 1-605-773-5509 Website: https://doh.sd.gov/diseases/infectious/ryanwhite/	Toll-free: 1-800-592-1861 Local: 1-605-773-3737 TTY/TDD: 711
South Dakota		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
South Dakota		
SHIP -- State Health Insurance Assistance Program	Senior Health Information & Insurance Education (SHIINE) 3801 South Western Avenue, Ste 105 Sioux Falls, SD 57105 Website: http://www.shiine.net	Toll-free: 1-800-536-8197 Local: 1-605-333-3314 TTY/TDD: 711
South Dakota		
State Department of Insurance	South Dakota Department of Labor and Regulation - Division of Insurance 124 S. Euclid Ave., 2nd Floor Pierre, SD 57501 Fax: 1-605-773-5369 Website: http://dlr.sd.gov/insurance/	Local: 1-605-773-3563 TTY/TDD: 711
South Dakota		
State Medical Assistance Office	Department of Social Services 700 Governors Drive, Pierre, SD 57501 Fax: 1-605-773-5246 Website: http://dss.sd.gov/medicaid/	Toll-free: 1-800-597-1603 Local: 1-605-773-3495 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

Tennessee		
AIDS Drug Assistance Program (ADAP)	Tennessee Department of Health - HIV/AIDS/STD Section: Ryan White Part B Director 4th Floor, Andrew Johnson Tower 710 James Robertson Parkway, Nashville, TN 37243 Fax: 1-615-741-3691 Website: http://www.tn.gov/health/section/STD	Local: 1-615-741-7500 TTY/TDD: 711
Tennessee		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Tennessee		
SHIP -- State Health Insurance Assistance Program	TN SHIP 502 Deaderick Street, 9th Floor Nashville, TN 37243 Fax: 1-615-741-3309 Website: http://www.state.tn.us/comaging/ship.html	Toll-free: 1-877-801-0044 Local: 1-615-741-2056 TTY/TDD: 711
Tennessee		
State Department of Insurance	Tennessee Department of Commerce and Insurance - Insurance Division 500 James Robertson Parkway, Davy Crockett Tower, 12th Floor Nashville, TN 37243 Fax: 1-615-532-7389 Website: www.tennessee.gov/commerce	Toll-free: 1-800-342-4029 Local: 1-615-741-2218 TTY/TDD: 711
Tennessee		
State Medical Assistance Office	TennCare Division of Health Care and Finance 310 Great Circle Rd., Nashville, TN 37243 Website: https://www.tn.gov/tenncare/section/members-applicants	Toll-free: 1-800-342-3145 Local: 1-855-259-0701 TTY/TDD: 711
Texas		
AIDS Drug Assistance Program (ADAP)	Texas Department of State Health Services P.O. Box 149347, MC 1873 Austin, TX 78714 Fax: 1-512-533-3178 Website: https://www.dshs.texas.gov/hivstd/meds/	Toll-free: 1-800-255-1090 Local: 1-512-533-3000 TTY/TDD: 1-800-735-2989
Texas		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100	Toll-free: 1-844-430-9504 Local: 1-216-447-9604

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	5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	TTY/TDD: 1-855-843-4776
Texas		
SHIP -- State Health Insurance Assistance Program	Dept. of Aging and Disability Services / Health Information Counseling and Advocacy Program (HICAP) 701 W. 51st St., Austin, TX 78751 Fax: 1-512-475-1771 Website: http://www.tdi.texas.gov/consumer/hicap/	Toll-free: 1-800-252-9240 TTY/TDD: 711
Texas		
State Department of Insurance	Texas Department of Insurance P.O. Box 149104, Austin, TX 78714 Fax: 1-512-490-1045 Website: http://www.tdi.texas.gov/	Toll-free: 1-800-578-4677 Local: 1-512-676-6000 TTY/TDD: 711
Texas		
State Medical Assistance Office	Texas Health and Human Services Commission PO BOX 149024, Austin, TX 78714 Website: https://hhs.texas.gov/	Toll-free: 1-877-541-7905 Local: 1-512-424-6500 TTY/TDD: 711
Texas		
State Pharmaceutical Assistance Program	Texas Department of State Health Services Kidney Health Care, Specialty Health Care Services, MC 1938, PO Box 149347 Austin, TX 78714 Fax: 1-512-776-7162 Website: https://www.dshs.texas.gov/kidney/	Toll-free: 1-800-222-3986 Local: 1-512-776-7150 TTY/TDD: 711
Utah		
AIDS Drug Assistance Program (ADAP)	Utah Department of Health - Bureau of Communicable Disease Control, Treatment and Care Services Program: ADAP Coordinator P.O. Box 142104, Salt Lake City, UT 84114 Fax: 1-801-536-0978 Website: http://health.utah.gov/epi/treatment/	Local: 1-801-538-6197 TTY/TDD: 711
Utah		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776

Addendum A: Important Contact Information for State Agencies

Utah		
SHIP -- State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIP) 195 North 1950 West, Salt Lake City, UT 84116 Fax: 1-801-538-4395 Website: http://daas.utah.gov	Toll-free: 1- 800-541-7735 Local: 1-801-538-3910 TTY/TDD: 711
Utah		
State Department of Insurance	Utah Insurance Department State Office Building Ste 3110 / Capitol Hill Complex, 450 N. State St. Salt Lake City, UT 84114 Fax: 1-801-538-3829 Website: http://www.insurance.utah.gov	Toll-free: 1-800-439-3805 Local: 1-801-538-3800 TTY/TDD: 711
Utah		
State Medical Assistance Office	Utah Department of Health Medicaid P.O. Box 143106, Salt Lake City, UT 84114 Fax: 1-801-538-6805 Website: http://health.utah.gov/medicaid/	Toll-free: 1-800-662-9651 Local: 1-801-538-6155 TTY/TDD: 711
Vermont		
AIDS Drug Assistance Program (ADAP)	Health Surveillance Division - Vermont Medication Assistance Program PO BOX 70, Drawer 41-IDEPI, Burlington, VT 5402 Fax: 1-802-863-7314 Website: http://healthvermont.gov/prevent/aids/aids_index.aspx	Toll-free: 1-800-244-7639 Local: 1-802-951-4005 TTY/TDD: 711
Vermont		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6671 Appeals Fax: 1-855-236-2423 Website: http://bfccqioarea1.com/	Toll-free: 1-866-815-5440 TTY/TDD: 1-866-868-2289
Vermont		
SHIP -- State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 481 Summer Street, Suite 101 St. Johnsbury, VT 05819 Website: http://www.cvaa.org/ship.html	Toll-free: 1-800-642-5119 Local: 1-802-748-5182 TTY/TDD: 711
Vermont		
State Department of Insurance	Vermont Department of Financial Regulation - Insurance Division 89 Main Street,	Toll-free: 1-800-964-1784 Local: 1-802-828-3301 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

	Montpelier, VT 05620 Fax: 1-802-828-1446 Website: http://www.dfr.vermont.gov/insurance/insurance-division	
Vermont		
State Medical Assistance Office	Green Mountain Care 312 Hurricane Ln., Ste. 201 Williston, VT 05495 Website: http://greenmountaincare.org	Toll-free: 1-800-250-8427 TTY/TDD: 711
Vermont		
State Pharmaceutical Assistance Program	Green Mountain Care - Prescription Assistance 312 Hurricane Ln., Williston, VT 05495 Website: http://greenmountaincare.org	Toll-free: 1-800-250-8427 TTY/TDD: 711
Virginia		
AIDS Drug Assistance Program (ADAP)	Virginia Department of Health - Virginia Aids Drug Assistance Program 109 Governor Street, HCS Unit, 1St Floor Richmond, VA 23219 Fax: 1-804-864-8050 Website: http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/	Toll-free: 1-855-362-0658 Local: 1-804-864-8145 TTY/TDD: 711
Virginia		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Virginia		
SHIP -- State Health Insurance Assistance Program	Virginian Division for the Aging - Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue, Suite 100 Henrico, VA 23229 Fax: 1-804-662-9354 Website: http://www.vda.virginia.gov	Toll-free: 1-800-552-3402 Local: 1-804-662-9333 TTY/TDD: 711
Virginia		
State Department of Insurance	Virginia State Corporation Commission - Bureau of Insurance P.O. Box 1157, Richmond, VA 23218 Website: http://www.scc.virginia.gov/boi/index.aspx	Toll-free: 1-800-552-7945 In State Only Local: 1-804-371-9741 TTY/TDD: 711
Virginia		
State Medical	Department of Medical Assistance Services	Toll-free: 1-800-643-2273

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Assistance Office	600 East Broad Street, Richmond, VA 23219 Website: http://dmasva.dmas.virginia.gov/default.aspx	Local: 1-804-786-7933 TTY/TDD: 1-800-343-0634
Virginia		
State Pharmaceutical Assistance Program	Virginia Division for the Aging - Prescription Drug Assistance Programs 1610 Forest Avenue, Suite 100 Henrico, VA 23229 Fax: 1-804-662-9354 Website: http://www.vda.virginia.gov/prescripassist1.asp	Toll-free: 1-800-552-3402 Local: 1-804-662-9333 TTY/TDD: 711
Washington		
AIDS Drug Assistance Program (ADAP)	Washington State Health Department - Aids Drug Assistance Program (ADAP) P.O. Box 47841, Olympia, WA 98504 Fax: 1-360-664-2216 Website: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP	Toll-free: 1-877-376-9316 Local: 1-360-236-3426 TTY/TDD: 711

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Washington		
Quality Improvement Organization	Livanta 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701 Fax: 1-844-420-6672 Appeals Fax: 1-855-694-2929 Website: http://bfccqioarea5.com	Toll-free: 1-877-588-1123 TTY/TDD: 1-855-887-6668
Washington		
SHIP -- State Health Insurance Assistance Program	Statewide Health Insurance Benefits Advisors (SHIBA) Helpline P.O. Box 40255, Olympia, WA 98504 Website: https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba	Toll-free: 1-800-562-6900 TTY/TDD: 1-800-833-6384
Washington		
State Department of Insurance	Washington State Office of the Insurance Commissioner P.O. Box 40256, Olympia, WA 98504 Website: http://www.insurance.wa.gov/	Toll-free: 1-800-562-6900 Local: 1-360-725-7000 TTY/TDD: 1-800-833-6384
Washington		
State Medical Assistance Office	Washington State Health Care Authority P.O. Box 45531, Olympia, WA 98504 Website: http://www.hca.wa.gov/medicaid/Pages/index.aspx x	Toll-free: 1-800-562-3022 TTY/TDD: 711
Washington		
State Pharmaceutical Assistance Program	Washington State Health Insurance Pool PO Box 1090, Great Bend, KS 67530 Fax: 1-620-793-1199 Website: https://www.wship.org/	Toll-free: 1-800-877-5187 TTY/TDD: 711
West Virginia		
AIDS Drug Assistance Program (ADAP)	West Virginia Department of Health & Human Resources - AIDS Task Force (ATF) PO Box 6360, Wheeling, WV 26003 Fax: 1-740-695-3252 Website: http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx	Toll-free: 1-800-434-9443 In State Only Local: 1-304-232-6822 TTY/TDD: 711

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West Virginia		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7129 Website: http://www.keproqio.com	Toll-free: 1-844-455-8708 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
West Virginia		
SHIP -- State Health Insurance Assistance Program	West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East, Charleston, WV 25305 Fax: 1-304-558-0004 Website: http://www.wvship.org	Toll-free: 1-877-987-4463 Local: 1-304-558-3317 TTY/TDD: 711
West Virginia		
State Department of Insurance	West Virginia Offices of the Insurance Commissioner PO Box 50540, Charleston, WV 25305 Fax: 1-304-558-4965 Website: http://www.wvinsurance.gov	Toll-free: 1-888-879-9842 Local: 1-304-558-3386 TTY/TDD: 711
West Virginia		
State Medical Assistance Office	West Virginia Department of Health & Human Resources - West Virginia Bureau for Medical Services 350 Capitol Street, Room 251 Charleston, WV 25301 Website: http://www.dhhr.wv.gov/bms/	Toll-free: 1-877-716-1212 Local: 1-304-558-1700 TTY/TDD: 711
Wisconsin		
AIDS Drug Assistance Program (ADAP)	Wisconsin Department of Health Services - Wisconsin AIDS/HIV Drug Assistance Program - ADAP PO Box 2659, Madison, WI 53701 Fax: 1-608-266-1288 Website: https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	Toll-free: 1-800-991-5532 Local: 1-608-267-6875 TTY/TDD: 711
Wisconsin		
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 Fax: 1-844-834-7130 Website: http://www.keproqio.com	Toll-free: 1-855-408-8557 Local: 1-813-280-8256 TTY/TDD: 1-855-843-4776
Wisconsin		
SHIP -- State Health Insurance Assistance Program	Wisconsin SHIP 1402 Pankratz Street, Madison, WI 53704	Toll-free: 1-800-242-1060 TTY/TDD: 711

Addendum A: Important Contact Information for State Agencies

Website: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm		
Wisconsin		
State Department of Insurance	Wisconsin Office of the Commissioner of Insurance P.O. Box 7873, Madison, WI 53707 Website: https://oci.wi.gov/Pages/Homepage.aspx	Toll-free: 1-800-236-8517 Local: 1-608-266-3585 TTY/TDD: 711
Wisconsin		
State Medical Assistance Office	Wisconsin Department of Health 1 West Wilson Street, Madison, WI 53703 Website: https://www.dhs.wisconsin.gov/medicaid	Toll-free: 1-800-362-3002 Local: 1-608-266-1865 TTY/TDD: 711
Wisconsin		
State Pharmaceutical Assistance Program	Wisconsin Department of Health Services - SeniorCare P. O. Box 6710, Madison, WI 53716 Fax: 1-608-250-6563 Website: http://www.dhs.wisconsin.gov/seniorcare/	Toll-free: 1-800-657-2038 TTY/TDD: 711
Wyoming		
AIDS Drug Assistance Program (ADAP)	Wyoming Department of Health - Communicable Disease Unit 6101 Yellowstone Rd, Suite 210 Cheyenne, WY 82002 Fax: 1-307-777-5279 Website: http://health.wyo.gov/publichealth/communicable-disease-unit/	Local: 1-307-777-7531 TTY/TDD: 711
Wyoming		
Quality Improvement Organization	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Fax: 1-844-878-7921 Website: http://www.keproqio.com	Toll-free: 1-844-430-9504 Local: 1-216-447-9604 TTY/TDD: 1-855-843-4776
Wyoming		
SHIP -- State Health Insurance Assistance Program	Wyoming State Health Insurance Information Program (WSHIIP) 106 West Adams Avenue Riverton, WY 82501 Fax: 1-307-856-4466 Website: http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	Toll-free: 1-800-856-4398 Local: 1-307-856-6880 TTY/TDD: 711
Wyoming		

Addendum A: Important Contact Information for State Agencies

State Department of Insurance	Wyoming Insurance Department 106 East 6th Avenue, Cheyenne, WY 82002 Fax: 1-307-777-2446 Website: http://insurance.state.wy.us/	Toll-free: 1-800-438-5768 In State Only Local: 1-307-777-7401 TTY/TDD: 711
Wyoming		
State Medical Assistance Office	Wyoming Department of Health - The Division of Healthcare Financing - Medicaid 6101 Yellowstone Rd, Ste. 259-D Cheyenne, WY 82002 Fax: 1-855-329-5205 Website: www.health.wyo.gov	Toll-free: 1-855-294-2127 Local: 1-307-777-7656 TTY/TDD: 1-855-889-4325

Addendum B – Aetna Medicare Plan (PPO) Service Areas*

Alabama				
Barbour	Dale	Houston	Mobile	
Chambers	Henry	Macon	Russell	
Arizona				
Graham	Maricopa	Pinal		
La Paz	Pima	Santa Cruz		
California				
Fresno	Orange	San Bernardino	San Francisco	
Los Angeles	Riverside	San Diego	Ventura	
Colorado				
Adams	Boulder	Denver	El Paso	
Arapahoe	Broomfield	Douglas	Jefferson	
Connecticut				
Fairfield	Litchfield	New London	Windham	
Hartford	Middlesex	Tolland		
	New Haven			
Delaware				
Kent	New Castle	Sussex		
District of Columbia				
Washington DC				
Florida				
Bradford	Collier	Lee	Orange	Saint Johns
Brevard	DeSoto	Manatee	Osceola	Saint Lucie
Broward	Duval	Marion	Palm Beach	Sarasota
Charlotte	Hernando	Martin	Pasco	Seminole
Citrus	Highlands	Miami-Dade	Pinellas	Volusia
Clay	Hillsborough	Nassau	Polk	
	Indian River			
	Lake			
Georgia				
Appling	Coweta	Gwinnett	Marion	Talbot
Baldwin	Crawford	Habersham	Meriwether	Taliaferro
Banks	Crisp	Hall	McDuffie	Tattnall
Barrow	Dawson	Hancock	McIntosh	Taylor
Bartow	DeKalb	Haralson	Monroe	Terrell
Ben Hill	Dooly	Harris	Morgan	Tift
Bibb	Dougherty	Hart	Muscogee	Toombs
Bleckley	Douglas	Heard	Murray	Towns
Bryan	Echols	Henry	Newton	Treutlen
Burke	Effingham	Houston	Oconee	Turner
Butts	Elbert	Irwin	Oglethorpe	Twiggs

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Addendum B: Aetna Medicare Plan (PPO) Service Areas

Camden	Emanuel	Jackson	Paulding	Union
Charlton	Evans	Jasper	Peach	Upson
Chatham	Fannin	Johnson	Pickens	Walton
Chattahoochee	Fayette	Jones	Pike	Warren
Cherokee	Forsyth	Lamar	Polk	Washington
Clarke	Franklin	Laurens	Putnam	Wayne
Clayton	Fulton	Lee	Quitman	White
Clinch	Gilmer	Liberty	Rabun	Worth
Cobb	Greene	Lincoln	Randolph	
Coffee		Long	Richmond	
Columbia		Lumpkin	Rockdale	
		Madison	Schley	
			Spalding	
			Stephens	
			Stewart	
			Sumter	
Illinois				
Bond	Ford	Livingston	Monroe	Warren
Boone	Fulton	Logan	Morgan	Washington
Bureau	Iroquois	Macoupin	Moultrie	White
Calhoun	Jersey	Madison	Ogle	Will
Cook	Kane	Marshall	Peoria	Winnebago
DeKalb	Kendall	Mason	Piatt	Woodford
Douglas	Lee	McHenry	Putnam	
Du Page		Menard	Sangamon	
Edgar		Mercer	St. Clair	
			Stark	
			Vermilion	
Indiana				
Adams	Decatur	Jefferson	Noble	Switzerland
Allen	Fayette	Jennings	Ohio	Tipton
Benton	Floyd	Johnson	Parke	Union
Blackford	Fountain	LaGrange	Porter	Vanderburgh
Boone	Franklin	Lake	Posey	Wabash
Brown	Gibson	Madison	Pulaski	Warren
Carroll	Hamilton	Marion	Putnam	Washington
Cass	Hancock	Marshall	Randolph	Wells
Clark	Harrison	Miami	Ripley	White
Clinton	Hendricks	Montgomery	Rush	Whitley
Crawford	Henry	Morgan	Scott	
De Kalb	Huntington	Newton	Shelby	
Dearborn	Jasper		Starke	
			Steuben	

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Iowa				
Pottawattamie				
Kansas				
Franklin Johnson	Leavenworth	Miami		
Kentucky				
Anderson	Campbell	Hardin	Larue	Pendleton
Boone	Carroll	Harrison	Lawrence	Powell
Bourbon	Carter	Henderson	Mason	Rowan
Boyd	Clark	Henry	Meade	Scott
Bullitt	Fayette	Jefferson	Montgomery	Shelby
	Franklin	Kenton	Nelson	Spencer
	Grant		Oldham	Woodford
	Greenup			
Louisiana				
Ascension	East Baton Rouge	Livingston	St. James	St. Martin
Assumption	Iberville	Orleans	St. John the Baptist	St. Mary
Bossier	Jefferson	St. Bernard	Baptist	St. Tammany
Caddo	Lafourche	St. Charles	St. Landry	Terrebonne
				West Baton Rouge
Maine				
Androscoggin	Hancock	Oxford	Sagadahoc	York
Aroostook	Kennebec	Penobscot	Somerset	
Cumberland	Knox	Piscataquis	Waldo	
Franklin	Lincoln			
Maryland				
Anne Arundel	Carroll	Garrett	Queen Annes	
Baltimore	Cecil	Harford	Saint Marys	
Baltimore City	Charles	Howard	Talbot	
Calvert	Dorchester	Kent	Washington	
Caroline	Frederick	Montgomery	Wicomico	
		Prince Georges	Worcester	
Massachusetts				
Bristol	Middlesex	Suffolk	Worcester	
Essex	Norfolk			
Hampden	Plymouth			
Michigan				
Allegan	Grand Traverse	Macomb	Oakland	Washtenaw
Antrim	Gratiot	Midland	Oceana	Wayne

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Arenac	Hillsdale	Missaukee	Ogemaw	Wexford
Benzie	Kalkaska	Monroe	Otsego	
Branch	Kent	Muskegon	Ottawa	
Calhoun	Leelanau	Newaygo	Roscommon	
Clare	Livingston		Saginaw	
Genesee			Sanilac	
Gladwin			St. Clair	
			Tuscola	
Mississippi				
DeSoto				
Missouri				
Benton	Greene	Lawrence	Saint Louis City	Wright
Christian	Henry	Lincoln	Stone	
Clay	Hickory	Platte	Warren	
Crawford	Jackson	Polk	Washington	
Dade	Jefferson	Ray	Webster	
Dallas	Johnson	Saint Charles		
Nebraska				
Dodge	Douglas	Lancaster	Sarpy	Washington
Nevada				
Clark	Washoe			
New Jersey				
Atlantic	Cumberland	Mercer	Passaic	Warren
Bergen	Essex	Middlesex	Salem	
Burlington	Gloucester	Monmouth	Somerset	
Camden	Hudson	Morris	Sussex	
Cape May	Hunterdon	Ocean	Union	
New Mexico				
Bernalillo	Sandoval	Torrance		
Cibola	Socorro	Valencia		
New York				
Albany	Cortland	Nassau	Putnam	Suffolk
Bronx	Delaware	New York	Queens	Sullivan
Broome	Dutchess	Oneida	Rensselaer	Tioga
Cayuga	Greene	Onondaga	Richmond	Tompkins
Chemung	Jefferson	Orange	Rockland	Ulster
Chenango	Kings	Orleans	Schenectady	Westchester
Columbia	Lewis	Oswego	Schuyler	Yates
	Madison		Seneca	
	Monroe		St. Lawrence	
			Steuben	

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Addendum B: Aetna Medicare Plan (PPO) Service Areas

North Carolina				
Alamance	Catawba	Gaston	Montgomery	Union
Alexander	Chatham	Gates	Orange	Vance
Alleghany	Cumberland	Guilford	Person	Wake
Burke	Davidson	Harnett	Polk	Wilkes
Cabarrus	Davie	Iredell	Randolph	Yadkin
Caldwell	Durham	Johnston	Richmond	
Caswell	Forsyth	Lee	Rockingham	
		Lincoln	Rowan	
		Mcdowell	Sampson	
		Mecklenburg	Scotland	
			Stokes	
Ohio				
Adams	Darke	Hocking	Miami	Scioto
Allen	Defiance	Holmes	Monroe	Seneca
Ashland	Delaware	Huron	Montgomery	Shelby
Ashtabula	Erie	Jackson	Morgan	Stark
Athens	Fairfield	Jefferson	Morrow	Summit
Auglaize	Fayette	Knox	Muskingum	Trumbull
Belmont	Franklin	Lake	Noble	Tuscarawas
Brown	Fulton	Lawrence	Ottawa	Union
Butler	Gallia	Licking	Paulding	Van Wert
Carroll	Geauga	Logan	Perry	Vinton
Champaign	Greene	Lorain	Pickaway	Warren
Clark	Guernsey	Lucas	Pike	Washington
Clermont	Hamilton	Madison	Portage	Wayne
Clinton	Hancock	Mahoning	Preble	Williams
Columbiana	Hardin	Marion	Putnam	Wood
Coshocton	Harrison	Medina	Richland	Wyandot
Crawford	Henry	Meigs	Ross	
Cuyahoga	Highland	Mercer	Sandusky	
Oklahoma				
Canadian	Kingfisher	Logan	Marshall	Pawnee
Cleveland	Lincoln	Major	Oklahoma	Seminole
Creek			Osage	Tulsa

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Pennsylvania				
Adams	Centre	Fulton	Mercer	Susquehanna
Allegheny	Chester	Greene	Mifflin	Tioga
Armstrong	Clarion	Huntingdon	Monroe	Union
Beaver	Clearfield	Indiana	Montgomery	Venango
Bedford	Clinton	Jefferson	Montour	Warren
Berks	Columbia	Juniata	Northampton	Washington
Blair	Crawford	Lackawanna	Northumberland	Wayne
Bradford	Cumberland	Lancaster	Perry	Westmoreland
Bucks	Dauphin	Lawrence	Philadelphia	Wyoming
Butler	Delaware	Lebanon	Pike	York
Cambria	Elk	Lehigh	Potter	
Cameron	Erie	Luzerne	Schuylkill	
Carbon	Fayette	Lycoming	Snyder	
	Forest	Mckean	Somerset	
	Franklin		Sullivan	
South Carolina				
Abbeville	Charleston	Chester	Pickens	Union
		Greenville		York
		Laurens		
South Dakota				
Lincoln				
Tennessee				
Cheatham	Rutherford	Trousdale		
Davidson	Shelby	Williamson		
Fayette				
Texas				
Anderson	Dallas	Haskell	Madison	Runnels
Aransas	Dawson	Hays	Marion	Rusk
Archer	Deaf Smith	Henderson	Martin	San Jacinto
Armstrong	Delta	Hidalgo	Mason	San Patricio
Atascosa	Denton	Hill	Matagorda	San Saba
Austin	DeWitt	Hockley	McCulloch	Schleicher
Bailey	Dickens	Hood	McLennan	Shackelford
Bandera	Dimmit	Hopkins	McMullen	Shelby
Bastrop	Donley	Hutchinson	Medina	Smith
Baylor	Duval	Irion	Menard	Somervell
Bee	El Paso	Jack	Milam	Starr
Bexar	Ellis	Jefferson	Mills	Sterling
Blanco	Falls	Jim Hogg	Montague	Stonewall
Borden	Fannin	Jim Wells	Montgomery	Sutton
Bosque	Fayette	Johnson	Moore	Swisher
Brazoria	Fisher	Jones	Morris	Tarrant
Brazos	Floyd	Karnes	Motley	Taylor
Briscoe	Fort Bend	Kendall	Nacogdoches	Terry

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Addendum B: Aetna Medicare Plan (PPO) Service Areas

Brooks	Franklin	Kenedy	Navarro	Throckmorton
Burleson	Freestone	Kent	Nolan	Travis
Burnet	Galveston	Kerr	Nueces	Trinity
Caldwell	Garza	Kimble	Oldham	Tyler
Callahan	Gillespie	Kleberg	Orange	Upshur
Cameron	Glasscock	Knox	Palo Pinto	Van Zandt
Camp	Goliad	Lamb	Panola	Walker
Carson	Gonzales	Lampasas	Parker	Waller
Cass	Gray	LaSalle	Polk	Washington
Castro	Grayson	Lavaca	Potter	Webb
Chambers	Gregg	Lee	Rains	Wharton
Cherokee	Grimes	Leon	Randall	Wheeler
Clay	Guadalupe	Liberty	Reagan	Willacy
Cochran	Hale	Limestone	Real	Williamson
Coke	Hall	Llano	Red River	Wilson
Coleman	Hamilton	Lubbock	Refugio	Wise
Collin	Hardin	Lynn	Roberts	Wood
Comal	Harris		Robertson	Young
Concho	Harrison		Rockwall	Zavala
Cooke	Hartley			
Coryell	Houston			
Crosby				
Utah				
Box Elder	Morgan	Summit	Utah	Weber
Davis	Rich	Tooele	Wasatch	
Duchesne	Salt Lake			

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Virginia				
Alexandria City	Falls Church	Hopewell City	Newport News	Salem City
Amelia	City	Isle of Wight	City	Spotsylvania
Arlington	Fauquier	James City	Northumberland	Stafford
Botetourt	Fluvanna	King and Queen	Petersburg City	Sussex
Caroline	Franklin	King George	Pittsylvania	Westmoreland
Charles City	Franklin City	King William	Poquoson City	Williamsburg
Chesterfield	Fredericksburg	Lancaster	Portsmouth City	City
Colonial	City	Loudoun	Powhatan	York
Heights City	Gloucester	Louisa	Prince George	
Craig	Goochland	Madison	Prince William	
Danville City	Grayson	Manassas City	Richmond City	
Dinwiddie	Greene	Manassas Park	Roanoke	
Essex	Hampton City	City	Roanoke City	
Fairfax	Hanover	Martinsville City		
Fairfax City	Henrico	Mathews		
	Henry	Middlesex		
		Nelson		
		New Kent		
Washington				
King	Mason	Pierce	Snohomish	Thurston
West Virginia				
Cabell	Marshall	Ohio	Putnam	Wood
Kanawha	Mason			
Wisconsin				
Kenosha	Ozaukee	Washington		
Milwaukee	Racine	Walworth		
	Sheboygan	Waukesha		

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1557 Disclaimer

Non-Discrimination Notice

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If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Aetna Medicare Grievance Department, P.O. Box 14067, Lexington, KY 40512. You can also file a grievance by phone by calling the phone number on your member identification card (TTY: 711). If you need help filing a grievance, the Aetna Medicare Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>. You can also contact the Aetna Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com, or by writing to Aetna Medicare Grievance Department, ATTN: Civil Rights Coordinator, P.O. Box 14067, Lexington, KY 40512. Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Aetna Medicare Plan (PPO) Customer Service

Method	Customer Service – Contact Information
CALL 	<p>Please call the telephone number printed on your member ID card or our general customer service center at 1-888-267-2637.</p> <p>Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.</p> <p>Customer Service also has free language interpreter services available for non-English speakers.</p>
TTY 	<p>711</p> <p>Calls to this number are free. We're available 8 a.m. to 6 p.m. local time, Monday through Friday.</p>
WRITE 	<p>Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088</p>
WEBSITE 	<p>http://www.aetnaretireplans.com</p>

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 on Addendum A of this *Evidence of Coverage*.

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.

AETNA LIFE INSURANCE COMPANY


Former Employer/Union/Trust Name: **STATE OF MAINE**
 Group Agreement Effective Date: **01/01/2018**
 Group Number: **457441**


This Schedule of Cost Sharing is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the attachment for information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay).*)


Annual Deductible	FOR SERVICES RECEIVED IN-NETWORK	FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED
This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered Medicare Part A and B services.	\$300 Deductible waived for Preventive Services, Part B Drugs, Diabetic Supplies, Emergency Room Visits, Emergency Ambulance, Urgent Care, applicable Riders and Renal Care and Temporomandibular Joint Dysfunction	\$300 Combined In- and Out-of-Network Deductible (Plan Level/includes network Deductible) Out-of-network: Deductible waived for Preventive Services, Emergency Room Visits, Emergency Ambulance, Urgent Care, and applicable Riders and Temporomandibular Joint Dysfunction
Annual Maximum Out-of-Pocket Limit		
The maximum out-of-pocket limit is the most you will pay for covered benefits including any deductible (if applicable).	Maximum out-of-pocket amount for in-network services: \$3,400	Combined maximum out-of-pocket amount for in- and out-of-network services: \$3,400



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




Table 1		
If you receive services from:	Your plan services include:	You will pay:
<p>A primary care physician (PCP):</p> <ul style="list-style-type: none"> • Family Practitioner • Pediatrician • Internal Medicine • General Practitioner <p>And get more than one covered service during the single visit:</p>	Copays only	One PCP copay.
	Copays and coinsurance	The PCP copay and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.
<p>An outpatient facility, specialist or doctor who is not a PCP and get more than one covered service during the single visit:</p>	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.


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



Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>	<p>20% of the cost for members eligible for this preventive screening.</p>


<p align="center">Services that are covered for you</p>	<p align="center">What you must pay (after any deductible listed on page 1) when you get these services</p> <p align="center">In-Network</p>	<p align="center">What you must pay (after any deductible listed on page 1) when you get these services</p> <p align="center">Out-of-network</p>
	<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required. <p>Prior authorization rules may apply for non-emergency transportation services received in-network. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.</p>	<p>\$25 copay for each Medicare-covered one-way trip.</p>
<p>Annual physical exam</p> <p>The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs; observation of general appearance; a head and neck exam; a heart and lung exam; an abdominal exam; a neurological exam; a dermatological exam; and an extremities exam. Coverage for this benefit is in addition to the Medicare-covered annual wellness visit and the “Welcome to Medicare” Preventive Visit.</p>	<p>\$0 copay for the exam.</p>	<p>20% of the cost of the exam.</p>
<p> Annual wellness visit</p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>	<p>20% of the cost for the annual wellness visit.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>		
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>	<p>20% of the cost for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months. 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>	<p>20% of the cost for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$20 copay for each Medicare-covered cardiac rehabilitation visit.</p>	<p>20% of the cost for each Medicare-covered cardiac rehabilitation visit.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>	<p>20% of the cost for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>	<p>20% of the cost for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Papt test within the past 3 years: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>	<p>20% of the cost for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <ul style="list-style-type: none"> • We cover manual manipulation of the spine to correct subluxation. <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$20 copay per Medicare-covered visit.</p>	<p>20% of the cost of each Medicare-covered visit.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>Enhanced chiropractic services: In addition to the chiropractic service described above, we cover other routine services you receive from a licensed chiropractor</p>	<p>\$20 copay for each visit.</p>	<p>\$20 copay for each visit.</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy <p>Please Note: A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the Outpatient surgery cost sharing. (See “Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers” for more information)</p>	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>	<p>20% of the cost for a Medicare-covered colorectal cancer screening exam.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services Out-of-network</p>
<p>Compression stockings</p> <p>Compression garments are usually made of elastic material, and are used to promote venous or lymphatic circulation. Compression garments worn on the legs can help prevent deep vein thrombosis and reduce edema, and are useful in a variety of peripheral vascular conditions.</p>	<p>\$0 per pair.</p>	<p>20% per pair.</p>
<p>Dental Services</p> <p>Medicare covered services include:</p> <ul style="list-style-type: none"> • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$25 copay for each Medicare-covered (non-routine) dental care service.</p>	<p>20% of the cost for each Medicare-covered (non-routine) dental care service.</p>
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>	<p>20% of the cost for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>	<p>20% of the cost for the Medicare covered diabetes screening tests.</p>

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<p>sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>		
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • Urine Test Strips 	<p>\$0 copay per Medicare-covered diabetic service or supply.</p> <p>\$0 for each pair of Medicare-covered diabetic shoes/inserts.</p> <p>\$0 copay for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit.</p> <p>\$0 copay for urine test strips.</p>	<p>20% of the cost per Medicare-covered diabetic service or supply.</p> <p>20% of the cost for each pair of Medicare-covered diabetic shoes/inserts.</p> <p>20% of the cost for the Medicare-covered diabetes self-management training preventive benefit.</p> <p>20% of the cost for urine test strips.</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of “durable medical equipment,” see the final chapter (“Definitions of important words”) of the <i>Evidence of Coverage</i>.)</p>	<p>\$0 copay for each Medicare-covered item.</p>	<p>20% of the cost for each Medicare-covered item.</p>


<p align="center">Services that are covered for you</p>	<p align="center">What you must pay (after any deductible listed on page 1) when you get these services</p> <p align="center">In-Network</p>	<p align="center">What you must pay (after any deductible listed on page 1) when you get these services</p> <p align="center">Out-of-network</p>
	<p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at http://www.aetnamedicaredocfind.com.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p> <ul style="list-style-type: none"> • Coverage for foot orthotics <p>We cover wigs for hair loss due to chemotherapy.</p>	<p>\$0 copay for foot orthotics.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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, loss of a limb, or loss of function of a limb. The medical symptoms may be</p>	<p>\$75 copay for each Medicare-covered emergency room visit.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p>	<p>\$75 copay for each Medicare-covered emergency room visit.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized,</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>This coverage is available worldwide.</p>		<p>you must move to a network hospital in order to pay the network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p>
<p> Health and wellness education programs</p> <ul style="list-style-type: none"> <p>Aetna Health ConnectionsSM — Disease Management This program provides individualized education and support for select chronic conditions. It can help you learn about how to manage your chronic health conditions and achieve your optimal state of health.</p> <p>Fitness Benefit The Aetna fitness benefit gives you a free monthly membership, including group exercise classes, at a participating fitness club and facility. Plan members who don't live close to a participating facility or want to exercise at home can order a home fitness kit. We work with another company to manage this benefit.</p> 		<p>There is no copay for any of the health and wellness education programs offered by our plan.</p> <p>Included in your plan.</p> <p>SilverSneakers[®] Fitness Program is included in your plan. We're here to help and give you more information.</p> <ul style="list-style-type: none"> Call us at 1-888-423-4632. (For TTY/TDD assistance please dial 711.) Visit http://www.silversneakers.com to find a participating location near you.

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<ul style="list-style-type: none"> • Healthy Lifestyle Coaching Program Offered through HealthyroadsTM and provides members with ongoing support and coaching to make positive changes in their health. The goal is to provide the most effective, individually focused intervention that seeks to change health behaviors and improve health. Members may receive a weekly 30 minute one-on-one telephonic based coaching session for stress management, nutrition, tobacco cessation, weight management, and exercise. Lifestyle coaching includes telephonic coaching, online tools, educational resources, and Milestone Kits. • Informed Health[®] Line Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options. • Resources for LivingSM – Resources For Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life related issues. • Written health education materials 	<p align="center">Healthy Lifestyle Coaching Program is included in your plan.</p> <ul style="list-style-type: none"> • Enroll by phone: 1-800 650-2747. (For TTY/TDD assistance please dial 711.) • Visit http://www.Healthyroads.com for additional information <p align="center">Included in your plan. Call us at 1-800-556-1555. (For TTY/TDD assistance please dial 711.)</p> <p align="center">Included in your plan. Call Resources for Living at 1-866-370-4842.</p> <p align="center">Included in your plan.</p>	
<p>Hearing services</p> <ul style="list-style-type: none"> • Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. 	<p>\$25 copay for basic hearing and balance evaluations.</p>	<p>20% of the cost for basic hearing and balance evaluations.</p>

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<ul style="list-style-type: none"> • Our plan covers one routine hearing exam every 12 months. • Hearing aid reimbursement Amounts you pay for hearing aids do not count toward your annual maximum out-of-pocket amount. 	<p>\$0 copay for one routine hearing exam every 12 months.</p> <p>Our plan will reimburse you up to \$500 once every 36 months towards the cost of hearing aids.</p>	<p>20% of the cost for one routine hearing exam every 12 months.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>	<p>20% of the cost for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services 	<p>\$0 copay for each Medicare-covered home health visit.</p> <p>\$0 copay for each Medicare-covered durable medical equipment item.</p>	<p>20% of the cost for each Medicare-covered home health visit.</p> <p>20% of the cost for each Medicare-covered durable medical equipment item.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> • Medical equipment and supplies <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p>



<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>prognosis, your cost for these services depends on whether you use a provider in our plan’s network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services. <p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan’s Part D benefit:</u> Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you’re in Medicare-certified hospice</i>).</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services for a terminally ill person who hasn’t elected the hospice benefit. Palliative care consultation is also available.</p>	<p>Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.</p>	<p>Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.</p>
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>	<p>\$0 copay for pneumonia, influenza, and Hepatitis B vaccines.</p>

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<ul style="list-style-type: none"> • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>\$0 copay for other Medicare-covered Part B vaccines.</p> <p>You may have to pay an office visit cost-share if you get other services at the same time that you get vaccinated.</p>	<p>20% of the cost for other Medicare-covered Part B vaccines.</p> <p>You may have to pay an office visit cost-share if you get other services at the same time that you get vaccinated.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</p> <p>There is no limit to the number of days covered by our plan. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services 	<p>For Medicare-covered hospital stays, you pay:</p> <p>\$0 per stay</p> <p>Cost-sharing is charged for each inpatient stay.</p>	<p>For Medicare-covered hospital stays:</p> <p>20% per stay</p> <p>Cost-sharing is charged for each inpatient stay.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or</p>		

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<p>by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p>Inpatient mental health care</p> <ul style="list-style-type: none"> Covered services include mental health care services that require a hospital stay. There is no limit to the number of days covered by our plan. <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>For Medicare-covered hospital stays, you pay:</p> <p>\$0 per stay</p> <p>Cost-sharing is charged for each inpatient stay.</p>	<p>For Medicare-covered hospital stays, you pay:</p> <p>20% per stay</p> <p>Cost-sharing is charged for each inpatient stay.</p>
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your skilled nursing facility (SNF) benefits or if the SNF or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> Physician services Diagnostic tests (like lab tests) X-ray, radium, and isotope therapy including technician materials and services 	<p>\$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p>\$0 copay for Medicare-covered diagnostic procedures or tests.</p>	<p>20% of the cost for each primary care doctor visit for Medicare-covered benefits.</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits.</p> <p>20% of the cost for Medicare-covered diagnostic procedures or tests.</p>

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<ul style="list-style-type: none"> • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition • Physical therapy, speech therapy, and occupational therapy <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for Medicare-covered lab services.</p> <p>\$5 copay for each Medicare-covered X-ray.</p> <p>\$50 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>\$0 copay for Medicare-covered therapeutic radiology services.</p> <p>\$5 copay for Medicare-covered medical supply items received from a PCP.</p> <p>\$25 copay for Medicare-covered medical supply items received from other providers.</p> <p>\$0 copay for each Medicare-covered prosthetic and orthotic item.</p> <p>\$0 copay for each Medicare-covered DME item.</p> <p>\$20 copay for each Medicare-covered physical, speech or</p>	<p>20% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for each Medicare-covered X-ray.</p> <p>20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>20% of the cost of service medical supply items received from a PCP.</p> <p>20% of the cost of service medical supply items received from other providers.</p> <p>20% of the cost for each Medicare-covered prosthetic and orthotic item.</p> <p>20% of the cost for each Medicare-covered DME item.</p> <p>20% of the cost for each Medicare-covered physical, speech or</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
	<p>occupational therapy visit.</p>	<p>occupational therapy visit.</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 3 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>	<p>20% of the cost for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>	<p>20% of the cost for Medicare-covered MDPP benefit.</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p>	<p>\$0 copay per prescription or refill.</p>	<p>20% of the cost per prescription or refill.</p>

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<ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen[®], Procrit[®], Epoetin Alfa, Aranesp[®], or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior</p>		

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services Out-of-network</p>
<p>authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>	<p>20% of the cost for preventive obesity screening and therapy.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic Radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details.</p> <p>\$5 copay for each Medicare-covered X-ray.</p> <p>\$50 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details.</p> <p>20% of the cost for each Medicare-covered X-ray.</p> <p>20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>20% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for Medicare-covered</p>

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
<p>pre-authorization of the service when provided by an out-of-network provider.</p>	<p>diagnostic procedures or tests.</p> <p>\$0 copay for Medicare-covered therapeutic radiology services.</p> <p>\$5 copay for Medicare-covered medical supply items received from a PCP.</p> <p>\$25 copay for Medicare-covered medical supply items received from other providers.</p>	<p>diagnostic procedures or tests.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>20% of the cost of service medical supply items received from a PCP.</p> <p>20% of the cost of service medical supply items received from other providers.</p>
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts 	<p>\$50 copay per facility visit.</p> <p>Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed.</p> <p>If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details.</p> <p>\$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>	<p>20% of the cost of the facility visit.</p> <p>20% of the cost for each primary care doctor visit for Medicare-covered benefits.</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered diagnostic procedures or tests.</p> <p>\$0 copay for each Medicare-covered mental health care visit.</p> <p>\$5 copay for each Medicare-covered X-ray.</p> <p>\$50 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>\$0 copay for Medicare-covered therapeutic radiology services.</p> <p>\$0 copay for each Medicare-covered partial hospitalization visit.</p> <p>\$5 copay for Medicare-covered medical supply items received from a PCP.</p> <p>\$25 copay for Medicare-covered medical supply items</p>	<p>20% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic procedures or tests.</p> <p>20% of the cost for each Medicare-covered mental health care visit.</p> <p>20% of the cost for each Medicare-covered X-ray.</p> <p>20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>20% of the cost for each Medicare-covered partial hospitalization visit.</p> <p>20% of the cost of service medical supply items received from a PCP.</p> <p>20% of the cost of service medical supply items received from other providers.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
	<p>received from other providers.</p> <p>\$0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.</p> <p>\$75 copay for each Medicare-covered emergency room visit.</p> <p>(Please Note: If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.)</p>	<p>20% of the cost per prescription or refill for certain drugs and biologicals that you can't give yourself.</p> <p>\$75 copay for each Medicare-covered emergency room visit.</p> <p>(Please Note: If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.)</p>
<p>Outpatient mental health care Covered services include:</p>	<p>\$0 copay for each Medicare-covered</p>	<p>20% of the cost for each Medicare-covered</p>



Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services	What you must pay (after any deductible listed on page 1) when you get these services
	In-Network	Out-of-network
<p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>individual or group therapy visit.</p>	<p>individual or group therapy visit.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$20 copay for each Medicare-covered outpatient rehabilitation service visit.</p>	<p>20% of the cost for each Medicare-covered outpatient rehabilitation service visit.</p>
<p>Outpatient substance abuse services</p> <p>Our coverage is the same as Original Medicare which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage</p>	<p>\$0 copay for each Medicare-covered individual or group therapy visit.</p>	<p>20% of the cost for each Medicare-covered individual or group therapy visit.</p>


<p align="center">Services that are covered for you</p>	<p align="center">What you must pay (after any deductible listed on page 1) when you get these services</p> <p align="center">In-Network</p>	<p align="center">What you must pay (after any deductible listed on page 1) when you get these services</p> <p align="center">Out-of-network</p>
	<p>available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Assessment, evaluation, and treatment for substance use related disorders by a Medicare eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment. • Brief interventions or advice focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details.</p> <p>\$50 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>\$50 copay for each Medicare-covered ambulatory surgical center visit.</p>	<p>20% of the cost for each Medicare-covered outpatient hospital facility visit.</p> <p>20% of the cost for each Medicare-covered ambulatory surgical center visit.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for each Medicare-covered visit.</p>	<p>20% of the cost for each Medicare-covered visit.</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, walk-in clinic, (non-urgent) or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Second opinion by another network provider prior to surgery 	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/ supplies - the setting where the tests/services/ supplies are performed. <p>If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details.</p> <p>\$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p>\$25 copay for each Medicare-covered</p>	<p>20% of the cost for each primary care doctor visit for Medicare-covered benefits.</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits.</p> <p>20% of the cost for each Medicare-covered</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>hearing and balance exams.</p> <p>\$25 copay for each Medicare-covered (non-routine) dental care service.</p> <p>\$0 copay for Medicare-covered allergy testing.</p>	<p>hearing and balance exams.</p> <p>20% of the cost for each Medicare-covered (non-routine) dental care service.</p> <p>\$0 copay for Medicare-covered allergy testing.</p>
<p>Podiatry services</p> <p>Medicare-covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs <p>Enhanced benefit: Non-Medicare covered routine podiatry - The reduction of nails, including mycotic nails and the removal of corns and calluses.</p>	<p>\$5 copay for Medicare-covered podiatry services received from your PCP.</p> <p>\$25 copay for each Medicare-covered podiatry services received from other providers.</p> <p>\$5 copay for routine podiatry services received from your PCP.</p> <p>\$20 copay for routine podiatry services received from other providers.</p>	<p>20% of the cost for Medicare-covered podiatry services received from your PCP.</p> <p>20% of the cost for each Medicare-covered podiatry services received from other providers.</p> <p>20% of the cost for routine podiatry services received from your PCP.</p> <p>20% of the cost for routine podiatry services received from other providers.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>	<p>20% of the cost for an annual PSA test.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for each Medicare-covered item.</p>	<p>20% of the cost for each Medicare-covered item.</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>\$20 copay for each Medicare-covered pulmonary rehabilitation visit.</p>	<p>20% of the cost for each Medicare-covered pulmonary rehabilitation visit.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>	<p>20% of the cost for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p>	<p>20% of the cost for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p>


<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>	<p>20% of the cost for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the Evidence of Coverage) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) 	<p>\$0 copay for kidney disease education services</p> <p>\$0 copay for in- and out-of area outpatient dialysis.</p> <p>Inpatient dialysis – refer to “Inpatient hospital care” at the beginning of this benefits chart.</p> <p>\$0 copay for self-dialysis training.</p>	<p>20% of the cost for self-dialysis training and kidney disease education.</p> <p>\$0 copay for in- and out-of area outpatient dialysis.</p> <p>Inpatient dialysis – refer to “Inpatient hospital care” at the beginning of this benefits chart.</p> <p>20% of the cost for self-dialysis training received from your PCP.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for home dialysis equipment and supplies.</p> <p>\$0 copay for Medicare-covered home support services.</p>	<p>20% of the cost for self-dialysis training received from other providers.</p> <p>20% of the cost for home dialysis equipment and supplies.</p> <p>20% of the cost for Medicare-covered home support services.</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see the final chapter (“Definitions of important words”) of the <i>Evidence of Coverage</i>. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>We cover 100 days per benefit period. A prior hospital stay is not required.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services 	<p>For Medicare-covered SNF stays, you pay:</p> <p>\$0</p> <p>A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing</p>	<p>For Medicare-covered SNF stays, you pay:</p> <p>20%</p> <p>A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</p>	<p>facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>	<p>20% of the cost for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Temporomandibular Joint Dysfunction (TMJ)</p> <p>Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint (jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments. Coverage is not provided for any procedure or device that alters the vertical relationship of the teeth or the relation of the mandible to the maxilla. Coverage for oral appliances is included. Dental services related to TMJ are not covered.</p> <p>Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for each visit.</p>	<p>\$0 copay for each visit.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services Out-of-network</p>
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Coverage is available worldwide.</p>	<p>\$20 copay for each Medicare-covered urgent care visit received at an urgent care facility.</p>	<p>\$20 copay for each Medicare-covered urgent care visit received at an urgent care facility.</p>
<p> Vision care</p> <p>Medicare-covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. 	<p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for one glaucoma screening every 12 months.</p> <p>\$0 copay for one diabetic retinopathy screening every 12 months.</p>	<p>20% of the cost for exams to diagnose and treat diseases and conditions of the eye.</p> <p>20% of the cost for one glaucoma screening every 12 months.</p> <p>20% of the cost for one diabetic retinopathy screening every 12 months.</p>

<p>Services that are covered for you</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services In-Network</p>	<p>What you must pay (after any deductible listed on page 1) when you get these services Out-of-network</p>
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) <p>Our plan covers one routine eye exam every 12 months.</p>	<p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.</p> <p>\$0 copay for one routine eye exam every 12 months.</p>	<p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.</p> <p>20% of the cost for one routine eye exam every 12 months.</p>
<p> “Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>	<p>20% of the cost for the “Welcome to Medicare” preventive visit.</p>

Note: See Chapter 4, Section 2.1 of the *Evidence of Coverage* for information on prior authorization rules.

Aetna Life Insurance Company

Former Employer/Union/Trust Name: STATE OF MAINE
Group Agreement Effective Date: 01/01/2018
Group Number: 457441

This *Prescription Drug Schedule of Cost Sharing* is part of the *Evidence of Coverage* (EOC) for our plan. When the EOC refers to the attachment for details of Medicare Part D prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart. (See the EOC chapters titled “Using the plan’s coverage for your Part D prescription drugs” and “What you pay for your Part D prescription drugs.”)

Annual Deductible Amount per Member	\$0
Formulary Type:	GRP B2 Plus
Number of Cost Share Tiers:	3 Tier
Initial Coverage Limit:	\$3,750
True Out-of-Pocket Amount:	\$5,000
Retail Pharmacy Network: S2	
The name of your pharmacy network is listed above. To find a network pharmacy, you can look in your <i>Pharmacy Directory</i> , visit our website (http://www.aetnamedicare.com/findpharmacy), or call Customer Service (phone numbers are printed on the back of your member ID card).	
Enhanced Drug Benefit	
We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan, including the following:	
<ul style="list-style-type: none">• Drugs when used for weight loss• Drugs when used to promote fertility• Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)• Drugs when used for the treatment of erectile dysfunction• DESI drugs	
The cost share for these drugs is listed in the table below. See Tier 1 for the generic cost share amount and Tier 2 for the brand cost share amount. **Drugs used for the treatment of sexual or erectile dysfunction and agents when used to promote fertility can be accessed at a \$50 member cost share.** The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. Limitations, such as quantity limits and prior authorization requirements, can be found in the formulary included in this mailing. In addition, if you are receiving “Extra Help” from Medicare to pay for your prescriptions, the “Extra Help” will not pay for these drugs. Please refer to your formulary or call Customer Service for more information.	

Every drug on the plan’s Drug List is in one of the cost-sharing tiers described below:

- Tier One – Generic drugs
- Tier Two – Preferred brand drugs
- Tier Three – Non-preferred brand drugs

To find out which cost-sharing tier your drug is in, look it up in the plan’s Drug List. If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Initial Coverage Stage: Amount you pay, up to \$3,750 in total covered prescription drug expenses.

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)	Standard retail or standard mail order cost-sharing (up to a 90-day supply)	Preferred mail order cost-sharing (up to a 90-day supply)
Tier 1 Generic drugs	\$10	\$10	\$10	\$10	\$10
Tier 2 Preferred brand drugs	\$30	\$30	\$30	\$30	\$30
Tier 3 Non-preferred brand drugs	\$45	\$45	\$45	\$45	\$45

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled “Using the plan’s coverage for your Part D prescription drugs,” Section 2.5.

Aetna MedicareSM Plan (PPO)
2018 Prescription Drug Schedule of Cost Sharing

Coverage Gap Stage: Amount you pay after you reach \$3,750 in total covered prescription drug expenses and until you reach \$5,000 in out-of-pocket covered prescription drug costs.

Your plan's gap coverage is listed in the chart below.

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)	Standard retail or standard mail order cost-sharing (up to a 90-day supply)	Preferred mail order cost-sharing (up to a 90-day supply)
Tier 1 Generic drugs	\$10	\$10	\$10	\$10	\$10
Tier 2 Preferred brand drugs	\$30	\$30	\$30	\$30	\$30
Tier 3 Non-preferred brand drugs	\$45	\$45	\$45	\$45	\$45

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Aetna MedicareSM Plan (PPO)

2018 Prescription Drug Schedule of Cost Sharing

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching \$5,000 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	You pay 5% of the drug cost or the amounts listed in the Initial Coverage Section, whichever is <i>less</i> .
	Our plan pays the rest of the cost.

Step Therapy

Your plan includes step therapy. This requirement encourages you to try less costly but 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 Plan Uses the GRP B2 Plus Formulary:

Your plan uses the GRP B2 Plus formulary, which means that only drugs on Aetna's drug list will be covered under your plan as long as the drug is medically necessary and the plan rules are followed. Non-preferred copayment levels may apply to some drugs on the drug list. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2018 Group Formulary (List of Covered Drugs)* for more information.