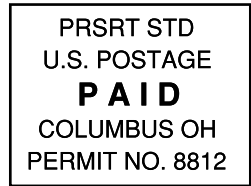




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Important Plan Information





151 Farmington Avenue, F265
Hartford, CT06156

Here's a copy of your Evidence of Coverage (EOC) for 2020

It's time to review your plan benefits

You can review the enclosed book about your plan benefits. You can also read how your plan coverage works.

The Centers for Medicare & Medicaid Services (CMS), the federal agency which administers the Medicare program, requires us to inform you about your coverage. In the EOC, you will find information on:

- Health care benefits and terms
- Conditions of coverage
- Program requirements and services, including our grievance and appeal procedures

If you are already an Aetna Medicare member and received an EOC booklet, please replace that one with this new version. Your new, 2020 EOC shows the plan benefits offered by your former employer/union/trust. Keep this copy for your records.

What you need to do

Now that you have your EOC, it's important to:

- Use this version as your 2020 Evidence of Coverage.
- Keep it handy so you can reference it.
- Review the entire booklet, especially the benefits chart (schedule of cost sharing) to see your 2020 benefits and costs.

We're here to help

Have any questions or comments? Call the toll-free telephone number on your member ID card.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. The pharmacy or provider network may change at any time. You will receive notice when necessary.

GRP_1095_753 09/2016

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MD-0298-14

Aetna Life Insurance Company

Former Employer/Union/Trust Name: **UNIVERSITY OF CHICAGO-RETIREE**

Group Agreement Effective Date: **01/01/2020**

Group Number: **467536**


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)*.)


	FOR SERVICES RECEIVED
Annual Deductible	
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.	\$150
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).	Combined maximum out-of-pocket amount for in- <u>and</u> out-of-network services: \$1,000

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

If you receive services from:	Your plan services include:	You will pay:
A primary care physician (PCP): <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.
An outpatient facility, specialist or doctor who is not a PCP and get more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.



 You will see this apple next to the 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
 <p>Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 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>You pay a \$35 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>You pay a \$0 copay for 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 update</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>






If you have questions, please call Customer Service at the telephone number listed on your member ID card.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>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> 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>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>You pay a \$35 copay for each Medicare-covered cardiac rehabilitation visit.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
 <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 healthy.</p>	<p>There is no coinsurance, copayment, or deductible 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>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>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 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>You pay a \$20 copay per Medicare-covered visit.</p>






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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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>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>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, 	<p>You pay a \$35 copay for each Medicare-covered (non-routine) dental care service.</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>or services that would be covered when provided by a physician)</p> <p>Prior authorization rules may apply for network services. Your 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> 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/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible 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 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>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</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. 	<p>You pay a \$0 copay per Medicare-covered diabetic service or supply.</p> <p>You pay \$0 for each pair of Medicare-covered diabetic shoes/inserts.</p> <p>\$0 copay for beneficiaries eligible for the Medicare-covered diabetes</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<ul style="list-style-type: none"> 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 	<p>self-management training preventive benefit.</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>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 aetnamedicare.com/findprovider.</p> <p>Prior authorization rules may apply for network services. Your 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>You pay 10% of the cost for each Medicare-covered item.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 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 pay a \$100 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> Health and wellness education programs</p> <ul style="list-style-type: none"> • 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>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.



If you have questions, please call Customer Service at the telephone number listed on your member ID card.

<p style="text-align: center;">Services that are covered for you</p>	<p style="text-align: center;">What you must pay (after any deductible listed on page 1) when you get these services</p>
<p>Hearing services</p> <p>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> <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>You pay a \$0 copay for one routine hearing exam every 12 months.</p> <p>Our plan will reimburse you up to \$500 every 12 months towards the cost of hearing aids.</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>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 	<p>You pay a \$0 copay for each Medicare-covered home health visit.</p> <p>You pay 10% of the cost for each Medicare-covered durable medical equipment item.</p>




If you have questions, please call Customer Service at the telephone number listed on your member ID card.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>total fewer than 8 hours per day and 35 hours per week)</p> <ul style="list-style-type: none"> • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p>Prior authorization rules may apply for network services. Your 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>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>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 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>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> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p> <p>You pay a \$35 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>



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<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>
<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>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 • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and 	<p>For Medicare-covered hospital stays, you pay:</p> <p>\$250 per stay</p> <p>Cost-sharing is charged for each inpatient stay.</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>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</p> <ul style="list-style-type: none"> • 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-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	




If you have questions, please call Customer Service at the telephone number listed on your member ID card.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>Prior authorization rules may apply for network services. Your 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 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: \$250 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 Surgical dressings Splints, casts and other devices used to reduce fractures and dislocations 	<p>You pay a \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>You pay a \$35 copay for each specialist visit for Medicare-covered benefits.</p> <p>You pay a \$0 copay for Medicare-covered lab services.</p> <p>You pay a \$35 copay for each Medicare-covered X-ray.</p> <p>You pay a \$35 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>You pay a \$35 copay for Medicare-covered therapeutic radiology services.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<ul style="list-style-type: none"> • 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 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>You pay a \$10 copay for Medicare-covered medical supply items received from a PCP.</p> <p>You pay a \$35 copay for Medicare-covered medical supply items received from other providers.</p> <p>You pay 10% of the cost for each Medicare-covered prosthetic and orthotic item.</p> <p>You pay 10% of the cost for each Medicare-covered DME item.</p> <p>You pay a \$35 copay for each Medicare-covered physical, speech or 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.</p> <p>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>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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>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> <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 Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically 	<p>You pay a \$35 copay per prescription or refill.</p>



If you have questions, please call Customer Service at the telephone number listed on your member ID card.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</p> <ul style="list-style-type: none"> Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>Part B drugs may be subject to step therapy requirements. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: aetna.com/partb-step.</p> <p>Prior authorization rules may apply for network services. Your 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> 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>Opioid Treatment Program Services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable Substance use counseling Individual and group therapy Toxicology testing 	<p>You pay \$35</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 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>You pay a \$35 copay for each Medicare-covered X-ray.</p> <p>You pay a \$35 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>You pay a \$0 copay for Medicare-covered lab services.</p> <p>You pay a \$35 copay for Medicare-covered diagnostic procedures or tests.</p> <p>You pay a \$35 copay for Medicare-covered therapeutic radiology services.</p> <p>You pay a \$10 copay for Medicare-covered medical supply items received from a PCP.</p> <p>You pay a \$35 copay for Medicare-covered medical supply items received from other providers.</p>
<p>Outpatient Hospital Observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation</p>	<p>Your cost share for Observation Care is based upon the services you receive.</p>



If you have questions, please call Customer Service at the telephone number listed on your member ID card.

<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>services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <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.</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-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p> <p>You can call these numbers for free, 24 hours a day, 7 days a week.</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 	<p>You pay a \$50 copay per facility visit.</p> <hr/> <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. <hr/> <p>You pay a \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <hr/> <p>You pay a \$35 copay for each specialist visit for Medicare-covered benefits.</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>certifies that inpatient treatment would be required without it</p> <ul style="list-style-type: none"> • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself <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-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Prior authorization rules may apply for network services. Your 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>You pay a \$0 copay for Medicare-covered lab services.</p> <p>For Medicare-covered mental health services, you pay \$35</p> <p>You pay a \$35 copay for each Medicare-covered X-ray.</p> <p>You pay a \$35 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>You pay a \$35 copay for Medicare-covered therapeutic radiology services.</p> <p>You pay a \$ 35 copay for each Medicare-covered partial hospitalization visit.</p> <p>You pay a \$10 copay for Medicare-covered medical supply items received from a PCP.</p> <p>You pay a \$35 copay for Medicare-covered medical supply items received from other providers.</p> <p>You pay a \$35 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.</p> <p>You pay a \$100 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>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>Outpatient mental health care</p> <p>Covered services include:</p> <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 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>You pay \$35</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 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>You pay a \$35 copay 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</p>	<p>You pay \$35</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.</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 network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 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>You pay a \$50 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>You pay a \$50 copay for each Medicare-covered ambulatory surgical center visit.</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 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>You pay a \$ 35 copay for each Medicare-covered visit.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 <i>by</i> another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing <p>Prior authorization rules may apply for network services. Your 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. <hr/> <p>You pay a \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>You pay a \$35 copay for each specialist visit for Medicare-covered benefits.</p> <p>You pay a \$35 copay for each Medicare-covered (non-routine) dental care service.</p>





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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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>You pay a \$10 copay for Medicare-covered podiatry services received from your PCP.</p> <p>You pay a \$35 copay for each Medicare-covered podiatry services received from other providers.</p>
<p>Podiatry services - enhanced benefit (Non-Medicare covered) routine podiatry - The reduction of nails, including mycotic nails and the removal of corns and calluses.</p>	<p>\$10 copay for routine podiatry services received from your PCP.</p> <p>\$35 copay for routine podiatry services received from other providers.</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>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 network provider is responsible for requesting prior authorization. Aetna</p>	<p>You pay 10% of the cost for each Medicare-covered item.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>recommends pre-authorization of the service when provided by an out-of-network provider.</p>	
<p>Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>You pay a \$30 copay for each Medicare-covered pulmonary rehabilitation visit.</p>
<p> Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible 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) For qualified individuals, a LDCT is covered every 12 months. 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>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p>



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<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><i>For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</i></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>Services to treat kidney disease</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 	<p>You pay a \$0 copay for self-dialysis training and kidney disease education services.</p> <p>You pay a \$30 copay for in- and out-of area outpatient dialysis.</p>




If you have questions, please call Customer Service at the telephone number listed on your member ID card.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>doctor, we cover up to six sessions of kidney disease education services per lifetime.</p> <ul style="list-style-type: none"> • 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) • 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 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 dialysis – refer to “Inpatient Hospital Care”</p> <p>You pay 10% of the cost for home dialysis equipment and supplies.</p> <p>You pay a \$0 copay 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>For Medicare-covered SNF stays, you pay:</p> <p>\$0 copay per day, day(s) 1-20; \$75 copay per day, day(s) 21-100</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</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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 • 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>Prior authorization rules may apply for network services. Your 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>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 facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.</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</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<p>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>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician’s office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques • SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. 	<p>You pay a \$30 copay for each service.</p>




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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<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>You pay a \$65 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>You pay a \$35 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>You pay a \$0 copay for one glaucoma screening every 12 months.</p> <p>You pay a \$0 copay for one diabetic retinopathy screening every 12 months.</p>



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Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals. (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>You pay a \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.</p> <p>You pay a \$0 copay 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>

Note: See Chapter 4, Section 2.1 of the *Evidence of Coverage* for information on prior authorization rules.



If you have questions, please call Customer Service at the telephone number listed on your member ID card.



Important reminder– provider directory

Our provider networks have changed. It is important to know if your provider(s) are in the network.

2020 Provider directories are available on **September 30, 2019**.

If you need help finding a provider, or if you'd like us to mail a directory to you, please call the number on your ID card for assistance.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage.

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2020 Evidence of Coverage

AETNA MedicareSM Plan (PPO)
Offered by AETNA Life Insurance Company





January 1 – December 31, 2020

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2020. It explains how to get coverage for the health care services 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).)

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. The document is available for free in Spanish.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021. The 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.

2020 Evidence of Coverage

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

SECTION 1 Introduction

Section 1.1 You are enrolled in the 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 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). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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

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 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 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).

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 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, 2020 and December 31, 2020.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

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.

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

service area. Addendum B at the back of this *Evidence of Coverage* lists the Aetna Medicare Plan (PPO) service areas. Your former employer/union/trust offers you coverage through our plan's extended service area feature which allows you to be covered in the areas that are not listed as an Aetna network service area.

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.

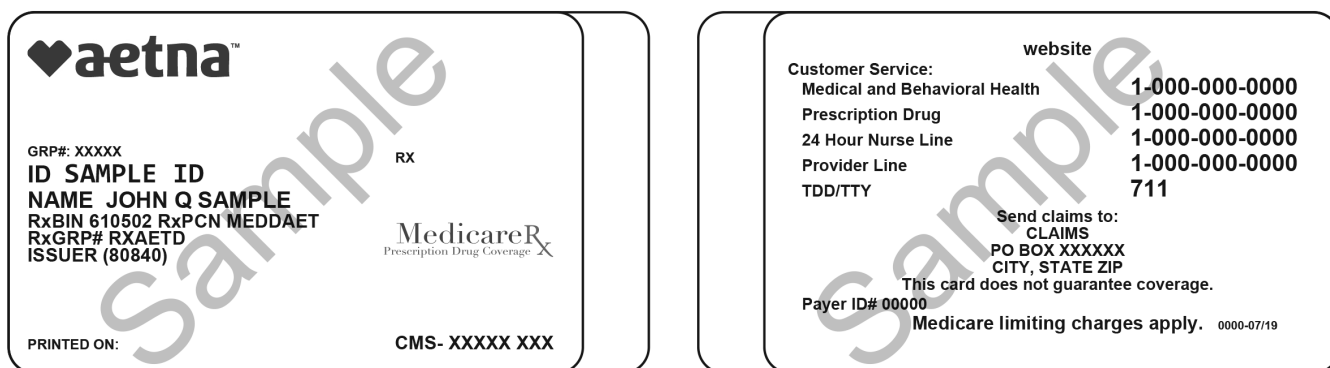
Section 2.4 U.S. citizen or lawful presence

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

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. You should also show the provider your Medicaid card, if applicable. Please continue to use your current Aetna Medicare ID card. A new card will be issued if there are changes made to the content printed on your card. Or, if you request one to be sent. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, in most cases, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of clinical research studies and hospice services). You may be asked to show your Medicare card if you



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

need hospital services for clinical research studies or hospice. 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 Directory*: Network providers

The *Provider Directory* lists our network providers and durable medical equipment suppliers. You are a member of our plan through our extended service area feature. Aetna Medicare may or may not have a provider network where you live.

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 may use network providers or out-of-network providers for all covered medical services at the same member cost sharing amount. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *Provider Directory*, and you reside in a network service area, you can request a copy from Customer Service (phone numbers are printed on your member ID card). A listing of network service areas is available in Addendum B at the back of this Evidence of Coverage. If you do not reside in a network service area, but you will be visiting a network service area in the future, you may still request a directory from us. You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at aetnamedicare.com/findprovider. 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>.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium (if applicable)?

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).

SECTION 5 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 have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2020* gives information about the Medicare premiums in the section called "2020 Medicare Costs." This explains how the Medicare Part B 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 2020* 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 5.1 There are several ways you can pay your plan premium (if applicable)

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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).

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

- 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 have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

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 7, Section 9 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.

Section 5.2 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.

SECTION 6 Please keep your plan membership record up to date

Section 6.1 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 and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services 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 questions, please call Customer Service at the telephone number listed on your member ID card.

- 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 8 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 7 We protect the privacy of your personal health information

Section 7.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 8 How other insurance works with our plan

Section 8.1 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 (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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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	<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>AetnaRetireePlans.com</p>



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7 (*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	aetnamedicare.com



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7 (*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 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	724-741-4953
WRITE	Aetna Medicare Part C Appeals & 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 aetnamedicare.com .



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7 (*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 Part C Grievance & Appeal Unit P.O. Box 14067 Lexington, KY 40512
AETNA WEBSITE	You can submit a complaint about our plan online at aetnamedicare.com/complaintsa-gcd .
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to medicare.gov/MedicareComplaintForm/home.aspx .



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Where to send a request asking us to pay for our share of the cost for medical care 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 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Request - Contact Information
WRITE	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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Method	Medicare – Contact Information
<p>WEBSITE</p>	<p>https://www.medicare.gov</p> <p>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.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • 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 <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <ul style="list-style-type: none"> • 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. <p>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.)</p>



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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 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. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	https://secure.rrb.gov/

SECTION 8 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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).
 - These providers in our network are listed in the *Provider & Pharmacy Direction*. You can also see the *Provider Directory* at aetnamedicare.com/findprovider.
 - **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 and non-Medicare covered services, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

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

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

As a member of our plan, you do not have to choose a network PCP; **however, we strongly encourage you to choose a PCP and let us know who you chose.** Your PCP can help you stay healthy, treat illnesses and coordinate your care with other health care providers. If you choose a network PCP, they will appear on your 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. If you choose a PCP that is not in our network, they will not appear on your ID card.

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

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

Please refer to your *Provider Directory* or access our website at aetnamedicare.com/findprovider for a complete listing of network PCPs in your area.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 network 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 network PCP by using the *Provider Directory*, or by accessing our website at aetnamedicare.com/findprovider, 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 network 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. 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 network PCP (such as home health services and durable medical equipment). They will check to see if the network 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 Directory* or access our website at aetnamedicare.com/findprovider 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 network PCP or other network 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 you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.
- 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 Directory* or at our website at aetnamedicare.com/findprovider.

Section 2.3 How to get care from out-of-network providers

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

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care and non-Medicare covered services, 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*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 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

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

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.

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

What if it wasn't a medical emergency?

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

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

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

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. 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?

Our plan covers urgently needed care you receive from network or out-of-network providers at the same cost sharing amount.

When circumstances are unusual or extraordinary, proceed to the nearest urgent care center for immediate treatment.

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

When you are outside the network service area, our plan covers urgently needed services that you receive from any provider at the same cost-sharing amount.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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: [AetnaRetireePlans.com](https://www.aetna.com/retireeplans) for information on how to obtain needed care during a disaster.

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 5 (*Asking us to pay our share of a bill you have received for covered medical services*) 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 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 7 (*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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

Section 5.1 What is a “clinical research study”?

A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. 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.

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?

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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 5 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:**

- 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.
- 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*.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

SECTION 7 Rules for ownership of durable medical equipment

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

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 preventive services. This means that we will pay our share of the costs for these services even if you haven’t paid your deductible yet. Refer to page 1 of the *Schedule of Cost Sharing* included with this *Evidence of Coverage* for a full list of services that are not subject to the plan deductible.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

Under our plan, there is a limit on what you have to pay out-of-pocket for covered medical services. This amount is shown on page 1 of your *Schedule of Cost Sharing* included with this *Evidence of Coverage*.

- 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) 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 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), 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 have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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.
- Sometimes your in network provider is required to receive approval in advance (sometimes called “prior authorization”) before we covered a service under the plan.
 - 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 never 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 have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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 2020* 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 2020, either Medicare or our plan will cover those services.

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

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 7, Section 5.3 in this booklet.)



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
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.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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		<p>✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</p> <p>✓ Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</p>
Routine dental care, such as cleanings, fillings or dentures.		<p>✓ Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i>.</p>
Non-routine dental care		<p>✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
Routine chiropractic care		<p>✓ 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>.</p>



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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 for people with diabetic foot disease. Additional coverage may be provided by your former employer. See your <i>Schedule of Cost Sharing</i> .
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, 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> .

 If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 5

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

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

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, 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 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. 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 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.)

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 7 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

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (aetnamedicare.com/forms) or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on your member ID card.)

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.

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 and how much we owe

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service 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.)
- If we decide that the medical care 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 explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

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 7 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 7. 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 7 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 7.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.)

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.)

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 ensure that you get timely access to your covered services

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.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

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

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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 Customer Service (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.

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.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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, 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.
- **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 have any questions, please call Customer Service at the telephone number listed on your member 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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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:

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079

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

² Aetna does not participate in pretext interviews.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

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.**
 - For example, you have the right to get information from us about the qualifications of the providers 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 Directory*.
 - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on your member ID card) or visit our website at AetnaRetireePlans.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - **You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.**



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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.
- 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 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 from an out-of-network provider.
 - If you are not happy or if you disagree with a decision we make about what medical care 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 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 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, see Chapter 5 of this booklet.

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

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

You have the right to 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:

- **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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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 7 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 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

What if your instructions are not followed?

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

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

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, 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 7 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 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Is it about something else?

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

- You can **call 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 1.8 How to get more information about your rights

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

- You can **call 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 “Medicare Rights & Protections.” (The publication is available at: <https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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).
 - 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 benefits you get from our plan with any other health 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.
- **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. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

(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.

- 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.
- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 7 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.
- **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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 7

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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

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."**



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

No. My problem is not about benefits or coverage.

Skip ahead to **Section 9** 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, 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. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think 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 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 you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

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 forwarded to Level 2. To request any appeal after Level 2, your doctor 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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three 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 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, 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.

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

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. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and service.

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.

? If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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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 this chapter because special rules apply to these types of care. Here's what to read in those situations:
 - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
 - Chapter 7, Section 7: *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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.”**

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 **for a medical item or service.** If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However, for a request for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need 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. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint” 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 9 of this chapter.)



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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** if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
 - **However, for a request for a medical item or service 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 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 9 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 on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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- 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" 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 9 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), or 24 hours if your request is for a Part B prescription drug, 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 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 on your request for a medical item or service, 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 on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will answer **within 72 hours of receiving your request**.
 - For a request for medical item or service, 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a "fast complaint" 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 9 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), or 72 hours if your request is for a Part B prescription drug, 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, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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).

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 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent 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 automatically send 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 on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” 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 9 of this chapter.)



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), 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, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send 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.

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.**



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all 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 your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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 or attorney adjudicator. Section 8 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 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 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.

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*).



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

SECTION 6 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*.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- 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 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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

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.)



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.”**



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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).



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 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 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further 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 an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

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.*



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.”** 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 9 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 you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.
 - 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 an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 7.1 *This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*

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 10, *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 10, *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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7.2 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Section 7.3 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 9 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7.5.

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.
- 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).



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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 an Administrative Law Judge or attorney adjudicator.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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, you can make a complaint. The complaint process is different from the appeal process. Section 9 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 you have any questions, please call Customer Service at the telephone number listed on your member ID card.

- **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 an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 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 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 (called an **Administrative Law Judge**) or an **attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says *yes* to your appeal, the appeals process *may* or *may not* be over** - 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 Administrative Law Judge's or attorney adjudicator's decision.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator 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 Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - 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 Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

MAKING COMPLAINTS

SECTION 9 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 9.1 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.

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 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, 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?

? If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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Complaint	Example
<p>Information you get from us</p>	<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?
<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 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>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, 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Section 9.2 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 9.3 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 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 Part C 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 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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
- 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 1-800-932-2159 (Expedited only) or fax your complaint to 1-724-741-4956. 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 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

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.
 - 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 9.5 You can also 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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

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 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, you are allowed to make plan changes at other times permitted by your plan sponsor.

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

All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment 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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

through your former employer/union/trust's group plan) you are eligible to end your membership at any time through a Special Enrollment Period.

Section 2.1 You can end your membership during the general Medicare Advantage Annual Enrollment Period

Notify your retiree medical benefits plan sponsor's benefits administrator that you would like to disenroll from our plan. The administrator will contact us and we will take the necessary steps to cancel your membership.

If you decide to disenroll from our plan and enroll in an individual Medicare Advantage plan, Original Medicare or another retiree medical benefits administrator-sponsored Medicare Advantage plan, you may want to verify that your disenrollment from our plan aligns with the timeframe for enrolling in the new plan. This will help you avoid a lapse in health care coverage. Enrolling in an individual market Medicare Advantage plan during the general Medicare Advantage Annual Enrollment Period held from October 15 to December 7 will end your membership in this plan.

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 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 2020*** 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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

Section 3.1 Usually, you end your membership by enrolling in another plan

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.

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 your benefits administrator.

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

Section 4.1 Until your membership ends, you are still a member of our plan

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 through our plan.

- **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 have any questions, please call Customer Service at the telephone number listed 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 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.

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 7, Section 9 for information about how to make a complaint.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

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If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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. This Medicare Advantage plan has been designed solely for retirees of your benefits plan sponsor.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. 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 within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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,
- 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



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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.

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.

SECTION 5 National Coverage Determination

Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services. When we receive coverage updates from Medicare, called National Coverage Determinations, we'll post the coverage updates on our website(s) at AetnaRetireePlans.com. You can also call Customer Service to obtain the coverage updates that have been posted for the benefit year.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

CHAPTER 10

Definitions of important words

Chapter 10. 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 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 an item, or service you think you should be able to receive. Chapter 7 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.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services 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 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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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. A copayment is a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services 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 are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

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.

Deductible – The amount (if applicable) you must pay for health care 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).

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. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.



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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.

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

Grievance – A type of complaint you make about us or one of our network providers, 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 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 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.

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



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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.

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

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. 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 or supplies, 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 Open Enrollment Period – A set time each year when members in a Medicare Advantage Plan can cancel their plan enrollment and switch to Original Medicare or make changes to your Part D coverage. Enrolling in an individual market Medicare Advantage plan during the general Medicare Advantage Annual Enrollment Period held from October 15 – December 7 will end your membership in this plan.

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



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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-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.

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).

“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 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 7 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



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doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network 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 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.”

Plan’s reimbursement rate – The amount a network provider agrees to accept as payment in full under its contract with us. The plan’s reimbursement rate is determined by our contract with our providers. Sometimes in our contracts we pay a set amount for each covered service that you receive based upon a fee schedule. Other times our provider contracts are value based contracts. This means that we pay providers for coordinating member care, improving clinical outcomes and efficiencies and providing covered services. When your provider has a value based contract with us, we will calculate the amount you have to pay, where applicable, using either a fee schedule in the provider contract or the Medicare payment rate for participating providers.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Your PPO plan has an annual limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

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. 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*.

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.

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.

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.



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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.

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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Addendum A

Quality Improvement Organizations (QIO)	
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	KEPRO , 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131, Toll-free Phone: 888-319-8452, Fax: 833-868-4055, TTY: 855-843-4776, Website: www.keproqio.com
Region 2: New Jersey, New York, Puerto Rico, Virgin Islands	Livanta , 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701, Toll-free Phone: 866-815-5440, Fax: 833-868-4056, TTY: 866-868-2289, Website: www.livantaqio.com
Region 3: Delaware, Maryland, Pennsylvania, Virginia, Washington, DC, West Virginia	Livanta , 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701, Toll-free Phone: 888-396-4646, Fax: 833-868-4057, TTY: 888-985-2660, Website: www.livantaqio.com
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	KEPRO , 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609, Toll-free Phone: 888-317-0751, Fax: 833-868-4058, TTY: 855-843-4776, Website: www.keproqio.com
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Livanta , 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701, Toll-free Phone: 888-524-9900, Fax: 833-868-4059, TTY: 888-985-8775, Website: www.livantaqio.com
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	KEPRO , 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609, Toll-free Phone: 888-315-0636, Fax: 833-868-4060, TTY: 855-843-4776, Website: www.keproqio.com
Region 7: Iowa, Kansas, Missouri, Nebraska	Livanta , 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701, Toll-free Phone: 888-755-5580, Fax: 833-868-4061, TTY: 888-985-9295, Website: www.livantaqio.com
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	KEPRO , 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131, Toll-free Phone: 888-317-0891, Fax: 833-868-4062, TTY: 855-843-4776, Website: www.keproqio.com
Region 9: Arizona, California, Hawaii, Nevada, Pacific Islands	Livanta , 10820 Guilford Rd., Suite 202, Annapolis Junction, MD 20701, Toll-free Phone: 877-588-1123, Fax: 833-868-4063, TTY: 855-887-6668, Website: www.livantaqio.com
Region 10: Alaska, Idaho, Oregon, Washington	KEPRO , 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131, Toll-free Phone: 888-305-6759, Fax: 833-868-4064, TTY: 855-843-4776, Website: www.keproqio.com

If no TTY number is listed, you may try 711 (National Relay Service)



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Addendum A

State Medicaid Offices	
AK	Alaska Department of Health and Social Services , 4501 Business Park Blvd., Bldg L, Anchorage, AK 99503-9972, Phone: 800-770-5650, Hours: M-F 8 a.m.-5 p.m., Website: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
AL	Alabama Medicaid Agency , P.O. Box 5624, Montgomery, AL 36103, Phone: 800-362-1504, Hours: M-F 8 a.m.-4:30 p.m., Website: www.medicaid.alabama.gov
AR	Arkansas Medicaid , P.O. Box 1437, Donaghey Plaza, Little Rock, AR 72203-1437, Phone: 800-482-8988, Hours: M-F 8 a.m.-4:30 p.m., Website: https://humanservices.arkansas.gov/about-dhs/dco/programs-services
AZ	Arizona Health Care Cost Containment , 801 E. Jefferson Street, Phoenix, AZ 85034, Phone: In State only: 602-417-4000, Out of State: 800-523-0231, Hours: M-F 8 a.m.-5 p.m., Website: www.azahcccs.gov
CA	California Department of Health Services Medi-Cal , 820 Stillwater Road, West Sacramento, CA 95605-1630, Phone: In State only: 800-541-5555, Out of State: 916-636-1980, Hours: M-F 8 a.m.-5 p.m., Website: http://www.medi-cal.ca.gov/
CO	Department of Health Care Policy and Financing of Colorado , 1570 Grant Street, Denver, CO 80203-1818, Phone: 800-221-3943, TTY: 800-659-2656, Hours: M-F 7:30 a.m.-5:15 p.m., Website: www.colorado.gov/hcpf
CT	Connecticut Department of Social Services , 55 Farmington Ave., Hartford, CT 06105, Phone: 855-626-6632, TTY: 800-842-4524, Hours: M-F 7:30 a.m.-4 p.m., Website: https://portal.ct.gov/DSS/Services/Health-and-Home-Care
DC	The Department of Health Care Finance , 441 4th Street, NW, 900S, Washington, DC 20001, Phone: 202-442-5988, Hours: M-F 8:15 a.m.-4:45 p.m., Website: http://dhcf.dc.gov/service/medicaid
DE	Delaware Health and Social Services , 1901 N. DuPont Highway, Lewis Bldg., New Castle, DE 19720, Phone: 800-372-2022, or 866-843-7212, Hours: M-F 8 a.m.-4:30 p.m., Website: http://dhss.delaware.gov/dhss/dmma/medicaid.html
FL	Florida Agency for Health Care Administration , 2727 Mahan Drive, Tallahassee, FL 32308, Phone: 888-419-3456, TTY: 800-955-8771. Hours: M-F 8 a.m.-5 p.m., Website: https://ahca.myflorida.com/Medicaid/index.shtml .
GA	Georgia Department of Community Health , 2 Peachtree Street, NW, Atlanta, GA 30303, Phone: 866-211-0950, Hours: M-F 8 a.m.-5 p.m., Website: https://medicaid.georgia.gov/
HI	Department of Human Services of Hawaii , P.O. Box 3490, Honolulu, HI 96811-3490, Phone: 877-628-5076, TTY: 855-585-8604, Hours: M-F 7:30 a.m.-4:30 p.m., Website: https://medquest.hawaii.gov/
IA	Department of Human Services of Iowa , P.O. Box 36510, Des Moines, IA 50315, Phone: 800-338-8366, Hours: M-F 8 a.m.-5 p.m., Website: http://dhs.iowa.gov/iahealthlink
ID	Idaho Department of Health and Welfare , P.O. Box 83720, Boise, ID 83720, Phone: 877-456-1233, Hours: M-F 8 a.m.-5 p.m., Website: www.healthandwelfare.idaho.gov

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Addendum A

State Medicaid Offices	
IL	Illinois Department of Healthcare and Family Services , 401 S. Clinton Street, Chicago, IL 60607, or 100 S. Grand Avenue, East, Springfield, IL 62762, Phone: 800-843-6154, TTY: 800-447-6404, Hours: M-F 8 a.m.-5 p.m., Website: http://www2.illinois.gov/hfs
IN	Indiana Medicaid , 2 N. Meridian St., Indianapolis, IN 46204, Phone: 1-800-382-9480, Hours: M-F 8 a.m.-4:30 p.m., Website: https://www.in.gov/medicaid/
KS	KanCare Kansas Medicaid , P.O. Box 3599, Topeka, KS 66601, Phone: 800-792-4884, TTY: 800-766-3777, Hours: M-F 8 a.m.-7 p.m., Website: http://www.kancare.ks.gov/
KY	Kentucky Cabinet for Health and Family Services , 275 E. Main Street, Frankfort, KY 40621, Phone: 1-800-372-2973, TTY: 800-627-4702, Hours: M-F 8 a.m.-5 p.m., Website: https://chfs.ky.gov/agencies/dms
LA	Louisiana Department of Health and Hospitals , P.O. Box 629, Baton Rouge, LA 70821-0629, Phone: Out of State only: 888-342-6207, In State: 225-342-9500, Hours: M-F 7 a.m.-5 p.m., Website: http://new.dhh.louisiana.gov/index.cfm/subhome/1/n/10
MA	Office of Health and Human Services of Massachusetts , 100 Hancock St., 6th Floor, Quincy, MA 02171, Phone: 800-841-2900, Hours: M-F 8 a.m.-5 p.m., Website: https://www.mass.gov/orgs/masshealth
MD	Department of Health and Mental Hygiene , 201 W. Preston Street, Baltimore, MD 21201, Phone: Out of State only: 877-463-3464, In State: 410-767-6500, Hours: M-F 8:30 a.m.-5 p.m., Website: https://mmcp.health.maryland.gov/pap
ME	Office of Mainecare Services , 11 State House Station, Augusta, ME 04333, Phone: 800-977-6740, or 207-287-2674, Hours: M-F 7 a.m.-6 p.m., Website: www.maine.gov/dhhs/oms
MI	Michigan Department of Health & Human Services , 333 S. Grand Ave, P.O. Box 30195, Lansing Michigan 48909, Phone: 855-275-6424, or 517-373-3740, TTY: 800-649-3777, Hours: M-F 8 a.m.-7 p.m., Website: www.michigan.gov/medicaid
MN	Minnesota Department of Human Services , P.O. Box 64993, St. Paul, MN 55164, Phone: 800-657-3739, TTY: 800-627-3529, Hours: M-F 8 a.m.-5 p.m., Website: https://mn.gov/dhs
MO	Missouri Department of Social Services , 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102, Phone: 800-392-2161, or 573-751-3425, TTY: 800-735-2966, Hours: M-F 7:30 a.m.-5:30 p.m., Website: mydss.mo.gov
MS	Mississippi Division of Medicaid , 200 South Lamar St., Jackson, MS 39201, Phone: 1-601-359-4500, Hours: M-F 8 a.m.-5 p.m., Website: https://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/
MT	Montana Department of Public Health & Human Services , 1400 Broadway, Cogswell Building, Helena, MT 59620, Phone: 800-362-8312, Hours: M-F 8 a.m.-5 p.m., Website: http://dphhs.mt.gov
NC	North Carolina Dept of Health and Human Services, Division of Medical Assistance , 2501 Mail Service Center, Raleigh, NC 27699-2501, Phone: 800-662-7030, or 919-855-4100, Hours: M-F 8 a.m.-5 p.m., Website: www.ncdhhs.gov/dma

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Addendum A

State Medicaid Offices	
ND	Dept of Human Services of North Dakota - Medical Services , 600 E. Boulevard Avenue, Dept 325, Bismarck, ND 58505, Phone: 800-755-2604, TTY: 800-366-6888, Hours: M-F 8 a.m.-5 p.m., Website: www.nd.gov/dhs/services/medicalserv/medicaid
NE	Nebraska Department of Health and Human Services System , 301 Centennial Mall South, Lincoln, NE 68508, Phone: 800-254-4202, TTY: 402-471-6035, Hours: M-F 8 a.m.-5 p.m., Website: http://dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx
NH	New Hampshire Department of Health and Human Services , 129 Pleasant Street, Concord, NH 03301, Phone: 603-271-4344, or 844-275-3447, TTY: 800-735-2964, Hours: M-F 8 a.m.-4 p.m., Website: http://www.dhhs.nh.gov/ombp/medicaid/
NJ	Department of Human Services of New Jersey , NJ Department of Human Services, Division of Medical Assistance and Health Services, P.O. Box 712, Trenton, NJ 08625, Phone: 800-356-1561, Hours: M-F 8 a.m.-5 p.m., Website: http://www.nj.gov/humanservices/dmahs/clients/medicaid/
NM	Department of Human Services of New Mexico , P.O. Box 2348, Santa Fe, NM 87504, Phone: 855-637-6574, or 888-997-2583, Hours: M-F 8 a.m.-4:30 p.m., Website: http://www.hsd.state.nm.us/LookingForAssistance/centennial-care-overview.aspx
NV	Nevada Department of Health and Human Services , 1100 E. William Street, Suite 102, Carson City, NV 89701, Phone: 877-638-3472, Hours: M-F 8 a.m.-5 p.m., Website: http://www.medicaid.nv.gov/
NY	New York State Department of Health Office of Medicaid Management , New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, Phone: 800-541-2831, Hours: M-F 8 a.m.-8 p.m., Website: http://www.health.ny.gov/health_care/medicaid/
OH	Ohio Department of Medicaid , 50 W. Town Street, Suite 400, Columbus, OH 43215, Phone: 800-324-8680, Hours: M-F 8 a.m.-5 p.m., Website: http://www.medicaid.ohio.gov
OK	Oklahoma Health Care Authority , 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, Phone: 800-987-7767, Hours: M-F 8 a.m.-5 p.m., Website: www.okhca.org
OR	Oregon Health Authority , 500 Summer Street, NE, Salem, OR 97301, Phone: Out of State only: 800-273-0557, In State: 503-945-5944, Hours: M-F 8 a.m.-5 p.m., Website: http://www.oregon.gov/oha/hsd/ohp
PA	Pennsylvania Department of Human Services , P.O. Box 2675, Harrisburg, PA 17105-2675, Phone: 800-692-7462, Hours: M-F 8 a.m.-5 p.m., Website: www.dhs.pa.gov
RI	Department of Human Services of Rhode Island , Louis Pasteur Building, 57 Howard Ave., Cranston, RI 02920, Phone: 855-697-4347, Hours: M-F 8:30 a.m.-4 p.m., Website: www.dhs.ri.gov
SC	South Carolina Healthy Connections Medicaid , P.O. Box 8206, Columbia, SC 29202, Phone: 888-549-0820, TTY: 888-842-3620, Hours: M-F 8 a.m.-6 p.m., Website: https://www.scdhhs.gov/
SD	Department of Social Services of South Dakota , 700 Governors Drive, Pierre, SD 57501, Phone: 800-452-7691, or 605-773-3165, Hours: M-F 8 a.m.-4:30 p.m., Website: https://dss.sd.gov/medicaid/

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Addendum A

State Medicaid Offices	
TN	Bureau of TennCare , 310 Great Circle Road, Nashville, TN 37243, Phone: 800-342-3145, TTY: 877-779-3103, Hours: M-F 8 a.m.-5 p.m., Website: www.tn.gov/tenncare
TX	Texas Health and Human Services Commission , 4900 N. Lamar Boulevard, Austin, TX 78751-2316, Phone: 800-252-8263, or 512-424-6500, Hours: M-F 7 a.m.-7 p.m., Website: http://www.hhsc.state.tx.us/medicaid/
UT	Utah Department of Health Medicaid , P.O. Box 143106, Salt Lake City, UT 84114-3106, Phone: 800-662-9651, Hours: M-F 8 a.m.-5 p.m., Website: https://medicaid.utah.gov/
VA	Virginia Medicaid , 600 E. Broad Street, Suite 1300, Richmond, VA 23219, Phone: 804-786-6145, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dmas.virginia.gov
VT	Green Mountain Care: Medicaid , 103 S. Main Street, Waterbury, VT 05671, Phone: 800-250-8427, Hours: M-F 8 a.m.-8 p.m., Website: http://www.greenmountaincare.org/mabd
WA	Washington Department of Social and Health Services , Health Care Authority, Box 45502, Olympia, WA 98504, Phone: 855-923-4633, Hours: M-F 8 a.m.-6 p.m., Website: https://www.wahealthplanfinder.org
WI	Wisconsin Department of Health Services , 1 W. Wilson Street, Madison, WI 53703, Phone: 800-362-3002, or 608-266-1865, TTY: 888-701-1251, Hours: M-F 8 a.m.-6 p.m., Website: https://www.dhs.wisconsin.gov/medicaid
WV	West Virginia Department of Health & Human Resources , One Davis Square, Suite 100 East, Charleston, WV 25301, Phone: 800-642-8589, or 304-558-0684, Hours: M-F 8 a.m.-4 p.m., Website: http://www.dhhr.wv.gov
WY	Wyoming Department of Health , 401 Hathaway Building, Cheyenne, WY 82002, Phone: 866-571-0944, Hours: M-F 8:30 a.m.-4:30 p.m., Website: www.health.wyo.gov

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State Health Insurance Assistance Program (SHIP)	
AK	Alaska State Health Insurance Assistance Program (SHIP) , 550 W. 8th Avenue, Anchorage, AK 99501, Phone: 800-478-6065, or 907-269-3680, TTY: 800-770-8973, Website: http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx
AL	State Health Insurance Assistance Program (SHIP) , Alabama Department of Senior Services, 201 Monroe Street, Suite 350, Montgomery, AL 36104, Phone: 800-243-5463, Website: www.alabamaageline.gov
AR	Seniors Health Insurance Information Program (SHIIP) , 1200 W. 3rd Street, Little Rock, AR 72201-1904, Phone: 800-224-6330, Website: https://insurance.arkansas.gov/pages/consumer-services/senior-health/
AZ	Arizona State Health Insurance Assistance Program (SHIP) , 1789 W. Jefferson, Site Code 050Z-1, Phoenix, AZ 85007, Phone: 800-432-4040, Website: https://des.az.gov/services/aging-and-adult/state-health-insurance-assistance-program-ship
CA	Health Insurance Counseling & Advocacy Program (HICAP) , 1300 National Drive, Suite 200, Sacramento, CA 95834, Phone: 800-434-0222, TTY: 800-735-2929, Website: https://www.aging.ca.gov/Providers_and_Partners/Health_Insurance_Counseling_and_Advocacy_Program/
CO	Senior Health Insurance Assistance Program (SHIP) , 1560 Broadway, Suite 850, Denver, CO 80202, Phone: 800-930-3745, Website: https://www.colorado.gov/dora/division-insurance
CT	Connecticut Program for Health Insurance Assistance, Outreach, Information & Referral Counseling and Elig. Screening (CHOICES) , 55 Farmington Avenue, Hartford, CT 06105-3730, Phone: In state: 866-218-6631, Out of State: 860-424-5274, TTY: 800-842-4524, Website: www.ct.gov/agingservices
DC	Health Insurance Counseling Project (HICP) , 500 K Street, NE, Washington, DC 20002, Phone: 202-994-6272, Website: https://dcoa.dc.gov/service/health-insurance-counseling
DE	The Delaware Medicare Assistance Bureau (DMAB) , DHSS Herman Holloway Campus, Lewis Building, 1901 N. DuPont Highway, New Castle, DE 19720, Phone: 800-336-9500, or 302-674-7364, Website: http://www.delawareinsurance.gov/DMAB/
FL	SHINE (Serving Health Insurance Needs of Elders) , 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, Phone: 800-963-5337, TTY: 800-955-8770, Website: www.floridaSHINE.org
GA	Georgia Cares , 2 Peachtree Street, NW, 33rd Floor, Atlanta, Georgia, 30303, Phone: 866-552-4464, Website: www.mygeorgiacares.org
HI	The Hawaii State Health Insurance Assistance Program (SHIP) , No. 1 Capitol District, 250 S. Hotel Street, Suite 406, Honolulu, HI 96813-2831, Phone: 808-586-7299, Website: www.hawaiiiship.org
IA	Senior Health Insurance Information Program (SHIIP) , 601 Locust Street, 4th Floor, Des Moines, IA 50309-3738, Phone: 800-351-4664, TTY: 800-735-2942, Website: https://shiip.iowa.gov/
ID	Senior Health Insurance Benefits Advisors (SHIBA) , P.O. Box 83720, Boise, ID 83720-0043, Phone: 800-247-4422, Website: http://www.doi.idaho.gov/shiba

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State Health Insurance Assistance Program (SHIP)	
IL	Senior Health Insurance Program (SHIP) , Illinois Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, Phone: 800-252-8966, Website: https://www.illinois.gov/aging/ship
IN	State Health Insurance Assistance Program (SHIP) , 311 W. Washington Street, Ste 300, Indianapolis, IN 46204-2787, Phone: 800-452-4800, TTY: 866-846-0139, Website: http://www.in.gov/idoi/2508.htm
KS	Senior Health Insurance Counseling for Kansas (SHICK) , 503 S. Kansas Avenue, Topeka, KS 66603-3404, Phone: 800-860-5260, Website: http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick
KY	State Health Insurance Assistance Program (SHIP) , 275 E. Main Street, Frankfort, KY 40621, Phone: 877-293-7447, Website: https://chfs.ky.gov/agencies/dail/Pages/ship.aspx
LA	Senior Health Insurance Information Program (SHIIP) , P.O. Box 94214, Baton Rouge, LA 70804, Phone: 800-259-5300, or 225-342-5301, Website: http://www.lidi.la.gov/SHIIP/
MA	Serving Health Information Needs of Elders (SHINE) , 1 Ashburton Place, 5th Floor, Boston, MA 02108, Phone: 800-243-4636, Website: https://www.mass.gov/health-insurance-counseling
MD	Maryland State Health Insurance , 301 W. Preston Street, Suite 1007, Baltimore, MD 21201, Phone: 800-243-3425, TTY: 410-767-1083, Website: https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx
ME	Maine State Health Insurance Assistance Program , 11 State House Station, 442 Civic Center Drive, Augusta, ME 04333-2723, Phone: 877-353-3771, TTY: 800-750-5353, Website: http://www.maine.gov/dhhs/oads/community-support/ship.html
MI	Medicare/Medicaid Assistance Program (MMAP) , 6105 W. St. Joseph Hwy., Suite 204, Lansing, MI 48917, Phone: 800-803-7174, Website: www.mmapinc.org
MN	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line , Metropolitan Area Agency on Aging, 2365 N. McKnight Road, Suite 3, North St. Paul, MN 55109, Phone: 800-333-2433, Website: http://www.mnaging.org/Advisor/SLL/SLL_SHIP.aspx
MO	Community Leaders Assisting the Insured of MO (CLAIM) , 200 North Keene Street, Suite 101, Columbia, MO 65201, Phone: 800-390-3330, Website: https://www.missouricclaim.org/
MS	MS Insurance Counseling and Assistance Program (MICAP) , 750 N. State Street, Jackson, MS 39202, Phone: 800-948-3090, Website: https://www.caregiver.org/mississippi-insurance-counseling-and-assistance-program-ship
MT	Montana Health Insurance Assistance Program (SHIP) , 1502 4th Street, West, Roundup, MT 59072, Phone: 800-551-3191, Website: https://dphhs.mt.gov/sltc/aging/SHIP
NC	The Seniors' Health Insurance Information Program (SHIIP) , 1201 Mail Service Center, Raleigh, NC 27699-1201, Phone: 855-408-1212, Website: www.ncshiip.com
ND	State Health Insurance Counseling Program (SHIC) , 600 E. Blvd., Dept. 401, Bismarck, ND 58505, Phone: 888-575-6611, TTY: 800-366-6888, Website: http://www.nd.gov/ndins/shic/

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State Health Insurance Assistance Program (SHIP)	
NE	Nebraska Senior Health Insurance Information Program (SHIIP) , 941 O Street, Suite 400, Lincoln, NE 68508, Phone: 800-234-7119, Website: http://www.doi.ne.gov/shiip
NH	NH SHIP - ServiceLink Resource Center , 129 Pleasant Street, Gallen State Office Park, Concord, NH 03301-3857, Phone: 866-634-9412, TTY: 800-735-2964, Website: http://www.servicelink.nh.gov/
NJ	State Health Insurance Assistance Program (SHIP) , P.O. Box 715, Mercerville, NJ 08625-0715, Phone: 800-792-8820, Website: http://www.state.nj.us/humanservices/doas/services/ship/index.html
NM	New Mexico ADRC/SHIP Benefits Counseling , P.O. Box 27118, Santa Fe, NM 87502-7118, Phone: 800-432-2080, Will call back, Website: http://www.nmaging.state.nm.us/adrc.aspx
NV	State Health Insurance Assistance Program (SHIP) , 3416 Goni Road, Suite D-132, Carson City, NV 89706, Phone: 800-307-4444, Website: http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
NY	Health Insurance Information Counseling and Assistance Program (HIICAP) , New York Office for the Aging, 2 Empire State Plaza, Agency Bldg. 2, 4th Floor, Albany, NY 12223-1251, Phone: 800-701-0501, Website: http://www.aging.ny.gov/HealthBenefits/Index.cfm
OH	Ohio Senior Health Insurance Information Program (OSHIIP) , 50 W. Town Street, 3rd Floor, Suite 300, Columbus, OH 43215, Phone: 800-686-1578, Website: http://www.insurance.ohio.gov/Consumer/OSHIIP/Documents/whatisoshiip.pdf
OK	Senior Health Insurance Counseling Program (SHICP) , 5 Corporate Plaza, 3625 NW 56th Street, Suite 100, Oklahoma City, OK 73112, Phone: 800-763-2828, Website: http://www.ok.gov/oid/Consumers/Information_for_Seniors/
OR	Senior Health Insurance Benefits Assistance (SHIBA) , Oregon Insurance Division, P.O. Box 14480, Salem, OR 97309, Phone: 800-722-4134, Website: www.oregonshiba.org
PA	APPRISE , 555 Walnut Street, 5th Floor, Harrisburg, PA 17101, Phone: 800-783-7067, Website: http://www.aging.pa.gov/aging-services/insurance/Pages/default.aspx
RI	Senior Health Insurance Program (SHIP) , 50 Valley Street, Providence, RI 02909, Phone: 401-462-0510, TTY: 401-462-0740, Website: http://www.dea.ri.gov/insurance/
SC	Insurance Counseling Assistance and Referrals for Elders (I-CARE) , P.O. Box 6668, Columbia, SC 29606, Phone: 800-868-9095, Other Areas of State: 864-242-9733, Website: https://www.getcaresc.com/guide/insurance-counseling-medicaremedicaid
SD	Senior Health Information and Insurance Education (SHIINE) , South Dakota Department of Social Services, 700 Governors Drive, Pierre, SD 57501, Phone: 800-536-8197, Website: www.shiine.net
TN	Tennessee State Health Insurance Assistance Program (SHIP) , 502 Deaderick Street, 9th Floor, Nashville, TN 37243, Phone: 877-801-0044, Website: https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html

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State Health Insurance Assistance Program (SHIP)	
TX	Health Information, Counseling and Advocacy Program (HICAP) , 701 W. 51st Street, MC: W352, Austin, TX 78751, Phone: 800-252-9240, TTY: 800-735-2989, Website: http://www.tdi.texas.gov/consumer/hicap/
UT	Health Insurance Information Program (HIIP) , 195 N 1950 W, Salt Lake City, UT 84116, Phone: 800-541-7735, Website: http://daas.utah.gov/
VA	Virginia Insurance Counseling and Assistance Project (VICAP) , 1610 Forest Avenue, Suite 100, Henrico, VA 23229, Phone: 800-552-3402, Website: http://www.vda.virginia.gov/vicap.htm
VT	State Health Insurance and Assistance Program (SHIP) , 76 Pearl Street, Suite 201, Essex Junction, VT 05452, Phone: 800-642-5119, Website: http://asd.vermont.gov/services/ship
WA	Statewide Health Insurance Benefits Advisors (SHIBA) Helpline , P.O. Box 40255, Olympia, WA 98504, Phone: 800-562-6900, TTY: 360-586-0241, Website: http://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/
WI	Wisconsin SHIP (SHIP) , Department of Health Services, 1 W. Wilson Street, Madison, WI 53703, Phone: 855-677-2783, Website: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
WV	West Virginia State Health Insurance Assistance Program (WV SHIP) , 1900 Kanawha Blvd., East, Charleston, WV 25305, Phone: 877-987-4463, Website: www.wvship.org
WY	Wyoming State Health Insurance Information Program (WSHIIP) , 106 West Adams, Riverton, WY 82501, Phone: 800-856-4398, Website: http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

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State Health Departments	
AK	Alaska Department of Health and Social Services, Phone: Toll-Free: 1-800-780-9972, Local: 907-269-3680, Hours: M-F 8 a.m.-5 p.m., Website: http://dhss.alaska.gov/Pages/default.aspx
AL	Alabama Department of Public Health, Phone: Toll-Free: 800-252-1818, Local: 334-206-5300, Hours: M-F 8 a.m.-5 p.m., Website: www.adph.org
AR	Arkansas Department of Health, Phone: Toll-Free: 800-462-0599, Local: 501-661-2000, Hours: M-F 8 a.m.-5 p.m., Website: www.healthy.arkansas.gov
AZ	Arizona Department of Health Services, Phone: Local: 602-542-1025, Hours: M-F 8 a.m.-5 p.m., Website: https://azdhs.gov/
CA	California Department of Health Services, Phone: Local: 916-445-4171, Hours: M-F 8 a.m.-5 p.m., Website: www.dhcs.ca.gov
CO	Colorado Department of Public Health and Environment, Phone: Local: 303-692-2000, Hours: M-F 8 a.m.-5 p.m., Website: www.cdph.e.state.co.us/
CT	Connecticut Department of Public Health, Phone: Local: 860-509-8000, Hours: M-F 8:30 a.m.-4:30 p.m., Website: www.ct.gov/dph
DC	The District of Columbia Department of Health, Phone: Local: 202-442-5955, Hours: M-F 8:15 a.m.-4:45 p.m., Website: www.doh.dc.gov
DE	Delaware Health and Social Services, Phone: Toll-Free: 800-372-2022, Local: 302-255-9040, Hours: M-F 8 a.m.-4:30 p.m., Website: http://dhss.delaware.gov/dhss/
FL	Florida Department of Health, Phone: Local: 850-245-4444, Hours: M-F 8 a.m.-5 p.m., Website: http://www.doh.state.fl.us/
GA	Georgia Department of Community Health, Phone: Toll-Free: 800-436-7442, Local: 404-656-4496, Hours: M-F 8 a.m.-5 p.m., Website: www.dch.georgia.gov
HI	Hawaii Department of Health, Phone: Local: 808-586-4400, Hours: M-F 7:45 a.m.-4:30 p.m., Website: www.hawaii.gov/health
IA	Iowa Department of Public Health, Phone: Toll-Free: 866-227-9878, Local: 515-281-7689, Hours: M-F 8 a.m.-4:30 p.m., Website: http://idph.iowa.gov/
ID	Idaho Department of Health and Welfare, Phone: Toll-Free: 800-926-2588, Local: 208-334-6700, Hours: M-F 8 a.m.-5 p.m., Website: http://healthandwelfare.idaho.gov

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State Health Departments	
IL	Illinois Department of Public Health, Phone: Local: 217-782-4977, Hours: M-F 8 a.m.-5 p.m., Website: www.idph.state.il.us
IN	Indiana State Department of Health, Phone: Toll-Free: 800-382-9480, Local: 317-233-1325, Hours: M-F 8:15 a.m.-4:45 p.m., Website: www.in.gov/isdh
KS	Kansas Department of Health and Environment, Phone: Local: 785-296-1500, Hours: M-F 8 a.m.-5 p.m., Website: http://www.kdheks.gov/health/index.html
KY	Kentucky Cabinet for Health & Family Services, Phone: Toll-Free: 800-372-2973, Local: 502-564-3970, Hours: M-F 8 a.m.-4:30 p.m., Website: https://chfs.ky.gov
LA	Louisiana Department of Health and Hospital, Phone: Local: 225-342-9500, Hours: M-F 8 a.m.-4:30 p.m., Website: www.dhh.louisiana.gov
MA	Massachusetts Department of Public Health, Phone: Toll-Free: 800-841-2900, Hours: M-F 9 a.m.-5 p.m., Website: www.mass.gov/dph
MD	Maryland Department of Health and Mental Hygiene, Phone: Toll-Free: 877-463-3464, Local: 410-767-6500, Hours: M-F 8 a.m.-4:30 p.m., Website: http://dhmh.maryland.gov/pages/index.aspx
ME	Maine Department of Health and Human Services, Phone: Local: 207-287-3707, Hours: M-F 8 a.m.-4:30 p.m., Website: www.state.me.us/dhhs
MI	Michigan Department Community Health, Phone: Local: 517-373-3740, Hours: M-F 8 a.m.-5 p.m., Website: www.michigan.gov/mdch
MN	Minnesota Department of Health, Phone: Toll-Free: 888-345-0823, Local: 651-201-5000, Hours: M-F 8 a.m.-4:30 p.m., Website: www.health.state.mn.us
MO	Missouri Department of Health & Senior Services, Phone: Local: 573-751-6400, Hours: M-F 8 a.m.-5 p.m., Website: www.dhss.mo.gov
MS	Mississippi Department of Health, Phone: Toll-Free: 866-458-4948, Local: 601-576-7400, Hours: M-F 8 a.m.-5 p.m., Website: www.msdh.state.ms.us/
MT	Montana Department of Public Health & Human Services, Phone: Toll-Free: 800-362-8312, Local: 406-444-4540, Hours: M-F 8 a.m.-5 p.m., Website: www.dphhs.mt.gov
NC	North Carolina Department of Health and Human Services, Phone: Local: 919-855-4800, Hours: M-F 8 a.m.-5 p.m., Website: www.ncdhhs.gov/dma

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Addendum A

State Health Departments	
ND	North Dakota Department of Health, Phone: Local: 701-328-2372, Hours: M-F 8 a.m.-5 p.m., Website: www.ndhealth.gov
NE	Nebraska Department of Health and Human Services, Phone: Toll-Free: 800-430-3244, Local: 402-471-3121, Hours: M-F 8 a.m.-5 p.m., Website: www.dhhs.ne.gov
NH	New Hampshire Department of Health and Human Services, Phone: Toll-Free: 844-275-3447, Local: 603-883-7726, Hours: M-F 8 a.m.-5 p.m., Website: www.dhhs.state.nh.us
NJ	State of New Jersey Department of Health, Phone: Toll-Free (24 Hrs): 800-792-9770, Local: 609-292-7837, Hours: M-F 7:30 a.m.-4:30 p.m., Website: www.state.nj.us/health/index.shtml
NM	New Mexico Department of Health, Phone: Local: 505-827-2613, Hours: M-F 8 a.m.-5 p.m., Website: https://nmhealth.org/
NV	Nevada Department of Health and Human Services, Phone: Local: 775-684-4000, Hours: M-F 8 a.m.-5 p.m., Website: http://dhhs.nv.gov/
NY	New York State Department of Health, Phone: Toll-Free: 800-541-2831, Hours: M-F 8:30 a.m.-3:30 p.m., Website: https://www.health.ny.gov/
OH	Ohio Department of Health, Phone: Local: 614-466-3543, Hours: M-F 8 a.m.-5 p.m., Website: www.odh.ohio.gov/
OK	Oklahoma State Department of Health, Phone: Toll-Free: 800-522-0203, Local: 405-271-5600, Hours: M-F 8 a.m.-5 p.m., Website: www.ok.gov/health
OR	Oregon Health Authority, Phone: Local: 971-673-1222, Hours: M-F 9 a.m.-4 p.m., Website: http://public.health.oregon.gov/Pages/Home.aspx
PA	Pennsylvania Department of Health, Phone: Toll-Free: 877-724-3258, Hours: M-F 8:30 a.m.-4:00 p.m., Website: www.health.state.pa.us
RI	Rhode Island Department of Health, Phone: Local: 401-222-5960, Hours: M-F 8:30 a.m.-4:30 p.m., Website: www.health.ri.gov
SC	South Carolina Department of Health and Environmental Control, Phone: Local: 803-898-3432, Hours: M-F 8 a.m.-5 p.m., Website: http://www.scdhec.gov/
SD	South Dakota Department of Health, Phone: Toll-Free: 800-738-2301, Local: 605-773-3361, Hours: M-F 8 a.m.-5 p.m., Website: https://doh.sd.gov/

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Addendum A

State Health Departments	
TN	Tennessee Department of Health, Phone: Local: 615-741-3111, Hours: M-F 8 a.m.-5 p.m., Website: https://www.tn.gov/health
TX	Texas Department of State Health Services, Phone: Toll-Free: 888-963-7111, Local: 512-458-7111, Hours: M-F 8 a.m.-5 p.m., Website: www.dshs.state.tx.us
UT	Utah Department of Health, Phone: Toll-Free: 888-222-2542, Local: 801-538-6003, Hours: M-F 8 a.m.-5 p.m., Website: www.health.utah.gov
VA	Virginia Department of Health, Phone: Local: 804-864-7001, Hours: M-F 8 a.m.-5 p.m., Website: www.vdh.state.va.us
VT	Vermont Department of Health, Phone: Toll-Free: 800-464-4343, Local: 802-863-7200, Hours: M-F 8 a.m.-5 p.m., Website: www.healthvermont.gov
WA	Washington State Department of Health, Phone: Toll-Free: 800-525-0127, Local: 360-236-4501, Hours: M-F 8 a.m.-5 p.m., Website: www.doh.wa.gov
WI	Wisconsin Department of Health, Phone: Local: 608-266-1865, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dhs.wisconsin.gov/
WV	West Virginia Department of Health & Human Resources, Phone: Local: 304-558-0684, Hours: M-F 8:30 a.m.-5 p.m., Website: http://www.dhhr.wv.gov/Pages/default.aspx
WY	Wyoming Department of Health, Phone: Toll-Free: 866-571-0944, Local: 307-777-7656, Hours: M-F 8 a.m.-5 p.m., Website: www.health.wyo.gov

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Addendum A

State Pharmaceutical Assistance Program (SPAP)	
CT	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE) , P.O. Box 5011, Hartford, CT 06102, Phone: 800-423-5026, or 860-269-2029, Website: https://portal.ct.gov/dors
DE	Delaware Chronic Renal Disease Program , 11-13 Church Avenue, Milford, DE 19963, Phone: 302-424-7180, or 800-464-4357, Hours: M-F 8 a.m.-4:30 p.m., Website: dhss.delaware.gov/dhss/dmma/crdprog.html
DE	Delaware Prescription Assistance Program , Phone: 800-996-9969, Website: https://dhss.delaware.gov/dhss/dmma/dpap.html
IN	Hoosier Rx , 402 W. Washington Street, Room W374, MS07, Indianapolis, IN 46204, Phone: 866-267-4679, or 317-234-1381, Hours: M-F 7 a.m.-3 p.m., Website: www.in.gov/fssa/ompp/2669.htm
MA	Massachusetts Prescription Advantage , P.O. Box 15153, Worcester, MA 01615-0153, Phone: 800-243-4636, Extension 2, TTY: 877-610-0241, Hours: M-F 8:45 a.m.-5 p.m., Website: http://www.mass.gov/elders/healthcare/prescription-advantage/
MD	Maryland Senior Prescription Drug Assistance Program (SPDAP) , c/o Pool Administrators, 628 Hebron Avenue, Suite 212, Glastonbury, CT 06033, Phone: 800-551-5995, TTY: 800-877-5156, Hours: M-F 8 a.m.-5 p.m., Website: http://marylandspdap.com
MD	Maryland Kidney Disease Program , 201 West Preston Street - Room SS-3, Baltimore, MD 21201, Phone: 410-767-5000, or 800-226-2142, Hours: M-F 8:30am-4:30pm EST, Website: http://www.mdrxprograms.com/kdp.html
MD	Primary Adult Care Program , P.O. Box 386, Baltimore, MD 21203, Phone: 800-226-2142
ME	Maine Low Cost Drugs for the Elderly or Disabled Program , Office of MaineCare Services, 242 State Street, Augusta, ME 04333, Phone: 866-796-2463, TTY: 800-606-0215, Website: http://www.maine.gov/dhhs/oads/home-support/elderly-physically-disabled/index.html
MO	Missouri Rx Plan , P. O. Box 6500, Jefferson City, MO 65102, Phone: 800-375-1406, Website: https://dss.mo.gov/morx/
MT	Montana Big Sky Rx Program , P.O. Box 202915, Helena, MT 59620-2915, Phone: 866-369-1233, or 406-444-1233, Hours: M-F 8 a.m.-5 p.m., Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx
MT	Montana Mental Health Services Plan , 555 Fuller Avenue, P.O. Box 202905, Helena, MT 59620, Phone: 406-444-3964, or 800-866-0328, Website: https://dphhs.mt.gov/amdd/services/mhsp
NJ	New Jersey Pharmaceutical Assistance to the Aged and Disabled (PAAD) , Division of Aging Services, P.O. Box 715, Trenton, NJ 08625-0715, Phone: 800-792-9745, Hours: M-F 8 a.m.-5 p.m., Website: http://www.state.nj.us/humanservices/doas/services/paad/
NJ	New Jersey Senior Gold Prescription Discount Program , P.O. Box 715, Trenton, NJ 08625-0715, Phone: 800-792-9745, Hours: M-F 8 a.m.-5 p.m., Website: http://www.state.nj.us/humanservices/doas/services/seniorgold/
NJ	New Jersey Division of Medical Assistance and Health Services , P. O. Box 712, Trenton, NJ 08625, Phone: 800-356-1561, Website: https://www.state.nj.us/humanservices/dmahs/home/index.html


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Addendum A

State Pharmaceutical Assistance Program (SPAP)	
NV	Nevada Disability Rx Program , Department of Health and Human Services, 3416 Goni Road, Building D, Suite 132, Carson City, NV 89706, Phone: 866-303-6323, or 775-687-4210, Hours: M-F 8 a.m.-5 p.m., Website: http://adsd.nv.gov/Programs/Physical/DisabilityRx/DisabilityRx/
NY	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) , P.O. Box 15018, Albany, NY 12212-5108, Phone: 800-332-3742, TTY: 800-290-9138, Hours: M-F 8 a.m.-5 p.m., Website: https://www.health.ny.gov/health_care/epic/
PA	Pharmaceutical Assistance Contract for the Elderly (PACE) , Pennsylvania Department of Aging, P.O. Box 8806, Harrisburg, PA 17105-8806, Phone: 800-225-7223, Hours: M-F 8 a.m.-5 p.m., Website: http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
PA	Special Pharmaceutical Benefits Program - Mental Health , Department of Public Welfare, Special Pharmaceutical Benefits Program, P.O. Box 8808, Harrisburg, PA 17105, Phone: 800-433-4459, Option 2, Website: http://www.dhs.pa.gov/provider/healthcaremedicalassistance/specialpharmaceuticalbenefitsprogram/index.htm
PA	Pennsylvania PACE Needs Enhancement Tier (PACENET) , Pennsylvania Department of Aging, P.O. Box 8806, Harrisburg, PA 17105-8806, Phone: 800-225-7223, Hours: M-F 8 a.m.-5 p.m., Website: http://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
PA	PACE Chronic Renal Disease Program (CRDP) , Pennsylvania Department of Health, Eligibility Unit, P.O. Box 8811, Harrisburg, PA 17105-8806, Phone: 800-225-7223, Hours: M-F 8 a.m.-5 p.m., Website: http://www.health.pa.gov/Your-Department-of-Health/Offices and Bureaus/Chronic Care/Pages/PA-Renal-Disease-Program.aspx
RI	RI Pharmaceutical Assistance to the Elderly (RIPAE) , 74 W. Road, Hazard Bldg., 2nd Floor, Cranston, RI 02920, Phone: 401-462-3000, Hours: M-F 8:30 a.m.-4 p.m., Website: http://www.dea.ri.gov/programs/prescription_assist.php
TX	Kidney Health Care Program (KHC) , Department of State Health Services, P.O. Box 149347, MC 1938, Austin, TX 78714-9347, Phone: 800-222-3986, or 512-776-7150, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dshs.texas.gov/kidney/
VT	V-Pharm , DCF - Economic Services Division, Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500, Phone: 800-250-8427, Hours: M-F 8 a.m.-8 p.m., from Nov 1-Dec 15, and 8 a.m.-5 p.m., all other times, Website: http://www.greenmountaincare.org/perscription
WI	Chronic Renal Disease , P.O. Box 6410, Madison, WI 53716, Phone: 800-362-3002, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm
WI	Cystic Fibrosis Program , P.O. Box 6410, Madison, WI 53716, Phone: 800-362-3002, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm
WI	Hemophilia Home Care , P.O. Box 6410, Madison, WI 53716, Phone: 800-362-3002, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dhs.wisconsin.gov/forwardhealth/wcdp.htm
WI	SeniorCare (above 200% FPL) , P.O. Box 6710, Madison, WI 53716, Phone: 800-657-2038, Hours: M-F 8 a.m.-5 p.m., Website: https://www.dhs.wisconsin.gov/seniorcare/index.htm
AK, AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MI, MN, MS, NC, ND, NE, NH, NM, OH, OK, OR, SC, SD, TN, UT, VA, WA, WV, WY	
No SPAP in these states	


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Addendum A

State AIDS Drug Assistance Programs (ADAP)	
AK	Alaska AIDS Drug Assistance Program (ADAP) , 1057 W. Fireweed Lane, Anchorage, AK 99503, Phone: 907-263-2050, Hours: M-F 8 a.m.-5 p.m., Website: http://www.alaskan aids.org/index.php/client-services/adap
AL	Alabama AIDS Drug Assistance Program (ADAP) , 201 Monroe Street, RSA Tower, Suite 1400, Montgomery, AL 36104, Phone: 866-574-9964, Hours: M-F 8 a.m.-4:30 p.m., Website: http://www.adph.org/aids/Default.asp?id=995
AR	Arkansas AIDS Drug Assistance Program (ADAP) , 4815 W. Markham, Little Rock, AR 72205, Phone: 888-499-6544, Hours: M-F 8 a.m.-4:30 p.m., Website: https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program
AZ	Arizona AIDS Assistance Program , 150 N.18th Avenue, Suite 110, Phoenix, AZ 85007, Phone: 602-364-4571, Hours: M-F 8 a.m.-5 p.m., Website: http://www.azdhs.gov/phs/hiv/adap/index.htm
CA	California AIDS Assistance Program (ADAP) / Ramsell Corporation , P.O. Box 997377, MS 0500, Sacramento, CA 95899-7377, Phone: 916-558-1784, or 888-311-7632, Hours: M-F 8 a.m.-5 p.m., Website: http://www.cdph.ca.gov/programs/aids/Pages/tOAADAPindiv.aspx
CO	Colorado AIDS Drug Assistance Program (ADAP) , 4300 Chery Creek Drive, South, Denver, CO 80246, Phone: 303-692-2716, Hours: M-F 7:30 a.m.-5:15 p.m., Website: https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap
CT	Connecticut AIDS Drug Assistance Program (CADAP) , 410 Capitol Avenue, P.O. Box 340308, Hartford, CT 06134, Phone: 800-233-2503, Hours: M-F 8 a.m.-5 p.m., Website: http://www.ct.gov/dph/cwp/view.asp?a=3135&Q=387012
DC	Washington DC AIDS Drug Assistance Program (DCADAP) , 899 North Capitol Street, NE, 4th Floor, Washington, DC 20002, Phone: 202-442-5955, Hours: M-F 8:15 a.m.-4:45 p.m., Website: https://dchealth.dc.gov/
DE	Delaware AIDS Drug Assistance Program (ADAP) , Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901, Phone: 302-744-1050, Hours: M-F 8 a.m.-4:30 p.m., Website: http://www.dhss.delaware.gov/dph/dpc/hivtreatment.html
FL	Florida AIDS Drug Assistance Program (ADAP) , HIV/AIDS Section, 4052 Bald Cypress Way, Tallahassee, FL 32399, Phone: 850-245-4334, Hours: M-F 8 a.m.-5 p.m., Website: http://www.floridahealth.gov/diseases-and-conditions/aids/adap/
GA	Georgia AIDS Drug Assistance Program (ADAP) , 2 Peachtree Street, NE, Atlanta, GA 30303, Phone: 404-657-3100, Hours: M-F 8 a.m.-5 p.m., Website: http://dph.georgia.gov/hiv-care-services
HI	Hawaii HDAP , 3627 Kilauea Avenue, Suite 306, Honolulu, HI 96816, Phone: 808-733-9360, Hours: M-F 7:30 a.m.-4:30 p.m., Website: http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/
IA	Iowa AIDS Drug Assistance Program (ADAP) , 321 E. 12th Street, Iowa State Office Building, Des Moines, IA 50319-0075, Phone: 515-242-5150, Hours: M-F 8 a.m.-5 p.m., Website: https://www.pparx.org/prescription_assistance_programs/iowa_aids_drug_assistance_program
ID	Idaho AIDS Drug Assistance Program (ADAP) , 450 W. State Street, P.O. Box 83720, Boise, ID 83720-0036, Phone: 208-334-5612, Hours: M-F 8 a.m.-5 p.m., Website: http://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx
IL	Illinois AIDS Drug Assistance Program (ADAP) , 525 W. Jefferson Street, 1st Floor, Springfield, IL 62761, Phone: 217-782-4977, Hours: M-F 8 a.m.-5 p.m., Website: http://www.idph.state.il.us/health/aids/adap.htm


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Addendum A

State AIDS Drug Assistance Programs (ADAP)	
IN	Indiana AIDS Drug Assistance Program (ADAP) , 2 N. Meridian Street, Indianapolis, IN 46204, Phone: 866-588-4948, or 317-233-7450, Hours: M-F 8 a.m.-4:30 p.m., Website: http://www.in.gov/isdh/17448.htm
KS	The Kansas Ryan White Part B Program , 1000 SW Jackson Street, Suite 210, Topeka, KS 66612, Phone: 785-296-6174, Hours: M-F 8 a.m.-5 p.m., Website: http://www.kdheks.gov/sti_hiv/ryan_white_care.htm
KY	Kentucky AIDS Drug Assistance Program (ADAP) , 275 E. Main Street, HS2E-C, Frankfort, KY 40601, Phone: 800-420-7431, Hours: M-F 8 a.m.-5 p.m., Website: http://chfs.ky.gov/dph/epi/HIVAIDS/
LA	Louisiana HIV/AIDS Program (LA HAP) , 1450 Poydras Street, Suite 2136, New Orleans, LA 70112, Phone: 504-568-7474, Hours: M-F 8 a.m.-5 p.m., Website: http://www.lahap.org/
MA	Massachusetts AIDS Drug Assistance Program (ADAP) , 380 Chauncy Street, Boston, MA 02111, Phone: 800-228-2714, Hours: M-F 8 a.m.-5 p.m., Website: http://crine.org/hdap/
MD	Maryland AIDS Assistance Program (MADAP) , 201 W. Preston Street, Baltimore, MD 21202, Phone: 800-205-6308, Hours: M-F 8:30 a.m.-4:30 p.m., Website: http://phpa.dhmm.maryland.gov/OIDPCS/CHCS/pages/madap.aspx
ME	Maine AIDS Drug Assistance Program (ADAP) , 286 Water Street, 11 State House Station, Augusta, ME 04333, Phone: 207-287-3747, Hours: M-F 7 a.m.-6 p.m., Website: http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/index.shtml
MI	Michigan AIDS Drug Assistance Program (MIDAP) , 109 Michigan Avenue, 9th Floor, Lansing, MI 48913, Phone: 888-826-6565, Hours: M-F 10 a.m.-6 p.m., Website: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982-44913--,00.html
MN	Minnesota HIV/AIDS Program – Program HH , P.O. Box 64972, St. Paul, MN 55164-0972, Phone: 651-431-2414, or 800-657-3761, Hours: M-F 8 a.m.-5 p.m., Website: http://www.mnidsproject.org/services/support-services/benefits-guide/program-hh.php
MO	Missouri HIV/AIDS Case Management Program , P.O. Box 570, Jefferson City, MO 65102, Phone: 573-751-6439, Hours: M-F 8 a.m.-5 p.m., Website: http://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
MS	Mississippi AIDS Drug Assistance Program (ADAP) , 570 E. Woodrow Wilson, Jackson, MS 39216, Phone: 601-576-7723, or 601-362-4879, Hours: M-F 8 a.m.-5 p.m., Website: http://msdh.ms.gov/index.htm
MT	Montana AIDS Drug Assistance Program (ADAP) , Cogswell Building, Room C-211, 1400 Broadway, Helena, MT 59620, Phone: 406-444-4744, Hours: M-F 8 a.m.-5 p.m., Website: http://www.dphhs.mt.gov/publichealth/hivstd/treatmentprogram.shtml
NC	North Carolina AIDS Drug Assistance Program (ADAP) , 2001 Mail Service Center, Raleigh, NC 27699, Phone: 919-855-4800, Hours: M-F 8 a.m.-5 p.m., Website: http://epi.publichealth.nc.gov/cd/hiv/adap.html
ND	North Dakota AIDS Drug Assistance Program (ADAP) , 2635 E. Main Avenue, Bismarck, ND 58506-5520, Phone: 800-706-3448, Hours: M-F 8 a.m.-5 p.m., Website: http://www.ndhealth.gov/HIV/default.htm
NE	Nebraska AIDS Drug Assistance Program (ADAP) , Nebraska Department of Health & Human Services, P.O. Box 95026, Lincoln, NE 68509-5026, Phone: 800-782-2437, or 402-552-9260, Hours: M-F 8 a.m.-5 p.m., Website: http://dhhs.ne.gov/publichealth/Pages/dpc_ryan_white.aspx

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Addendum A

State AIDS Drug Assistance Programs (ADAP)	
NH	New Hampshire AIDS Drug Assistance Program (ADAP) , 29 Hazen Drive, Concord, NH 03301, Phone: 603-271-4502, or 800-852-3345 x4502, Hours: M-F 8:30 a.m.-4:30 p.m., Website: http://www.dhhs.nh.gov/dphs/bchs/std/care.htm
NJ	New Jersey AIDS Drug Assistance Program (ADAP) , P.O. Box 715, Trenton, NJ 08625-0715, Phone: 877-613-4533, Hours: M-F 8 a.m.-5 p.m., Website: http://www.state.nj.us/humanservices/doas/home/freemed.html#addp
NM	New Mexico AIDS Drug Assistance Program (ADAP) , 1190 St. Francis Drive, Room S 1200, Santa Fe, NM 87502, Phone: 505-476-2351, Hours: M-F 8 a.m.-5 p.m., Website: https://www.pparx.org/prescription_assistance_programs/new_mexico_aidshiv_drugs_assistance_program
NV	Nevada AIDS Drug Assistance Program (ADAP) , 4150 Technology Way, Carson City, NV 89706-2009, Phone: 775-684-4247, Hours: M-F 8 a.m.-5 p.m., Website: http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/
NY	New York AIDS Drug Assistance Program (ADAP) , HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052, Phone: 800-542-2437, Hours: M-F 8 a.m.-5 p.m., Website: http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm
OH	Ohio AIDS Drug Assistance Program (OHDAP) , 246 N. High Street, 6th Floor, Columbus, OH 43215, Phone: 800-777-4775, Hours: M-F 8 a.m.-5 p.m., Website: http://www.odh.ohio.gov/odhprograms/hastpac/hivcare/OHDAP/drgasst1.aspx
OK	Oklahoma AIDS Drug Assistance Program (ADAP) , 1000 NE 10th Street, Mail Drop 0308, Oklahoma City, OK 73117, Phone: 405-271-4636, Hours: M-F 8 a.m.-5 p.m., Website: https://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/Care_Delivery_(Ryan_White_ADAP_Hepatitis)/index.html
OR	Oregon CAREAssist , 800 NE Oregon Street, Suite 1105, Portland, OR 97232, Phone: 800-805-2313, Hours: M-F 8 a.m.-5 p.m., Website: http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
PA	Pennsylvania Special Pharmaceutical Benefits Program – HIV/AIDS , P.O. Box 8808, Harrisburg, PA 17105-8808, Phone: 800-922-9384, Hours: M-F 8 a.m.-5 p.m., Website: http://www.health.pa.gov/MyHealth/DiseasesandConditions/E-H/HIVAndAIDSEpidemiology/Pages/Special-Pharmaceutical-Benefits-Program.aspx
RI	Rhode Island AIDS Drug Assistance Program (ADAP) , 3 Capitol Hill, Providence, RI 02908, Phone: 401-222-5960, Hours: M-F 8:30 a.m.-4:30 p.m., Website: http://www.health.ri.gov/diseases/hiv aids/
SC	South Carolina AIDS Drug Assistance Program (ADAP) , 2600 Bull Street, Columbia, SC 29201, Phone: 803-898-3432, Hours: M-F 8 a.m.-6 p.m., Website: http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/
SD	South Dakota AIDS Drug Assistance Program (ADAP) , 600 E. Capital Avenue, Pierre, SD 57501, Phone: 605-773-3361, Hours: M-F 8 a.m.-4:30 p.m., Website: http://doh.sd.gov/diseases/infectious/HIV-AIDS/
TN	Tennessee AIDS Drug Assistance Program (ADAP) , Andrew Johnson Tower, 4th Floor, 710 James Robertson Parkway, Nashville, TN 37243, Phone: 615-741-7500, Hours: M-F 8 a.m.-5 p.m., Website: https://tn.gov/health/topic/STD-ryanwhite
TX	Texas AIDS Drug Assistance Program (ADAP) , P.O. Box 149347, MC 1873, Austin, TX 78714, Phone: 512-533-3000, Hours: M-F 8 a.m.-5 p.m., Website: http://www.dshs.state.tx.us/hivstd/meds/spap.shtm

If no TTY number is listed, you may try 711 (National Relay Service)



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Addendum A

State AIDS Drug Assistance Programs (ADAP)	
UT	Utah Bureau AIDS Drug Assistance Program (ADAP) , P.O. Box 142104, Salt Lake City, UT 84114, Phone: 801-538-6191, Hours: M-F 8 a.m.-5 p.m., Website: http://health.utah.gov/epi/treatment/
VA	Virginia AIDS Drug Assistance Program (ADAP) , 109 Governor Street, Richmond, VA 23219, Phone: 855-362-0658, Hours: M/W 8:30 a.m.-6 p.m., T/Th/F 8:30 a.m.-5 p.m., Website: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/index.htm
VT	Vermont Medication Assistance Program (VMAP) , 108 Cherry Street, P.O. Box 70, Burlington, VT 05402-0070, Phone: 802-951-4005, Hours: M-F 7:45 a.m.-3:30 p.m., Website: https://www.pparx.org/prescription_assistance_programs/vermont_medication_assistance_program
WA	Washington AIDS Drug Assistance Program (ADAP) , P.O. Box 47841, Olympia, WA 98504, Phone: 877-376-9316, Hours: M-F 8 a.m.-5 p.m., Website: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices.aspx
WI	Wisconsin AIDS Drug Assistance Program (ADAP) , 1 W. Wilson Street, Madison, WI 53703, Phone: 800-991-5532, or 608-267-6875, Hours: M-F 8 a.m.-4 p.m., Website: https://www.dhs.wisconsin.gov/aids-hiv/adap.htm
WV	West Virginia AIDS Drug Assistance Program (ADAP) , 350 Capital Street, Room 125, Charleston, WV 25301, Phone: 800-642-8244, Hours: M-F 8 a.m.-4 p.m., Website: http://www.dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx
WY	Wyoming AIDS Drug Assistance Program (ADAP) , 6101 N. Yellowstone Road, Room 510, Cheyenne, WY 82002, Phone: 307-777-5856, Hours: M-F 8:30 a.m.-4:30 p.m., Website: http://www.health.wyo.gov/phsd/howpa/forms.html

If no TTY number is listed, you may try 711 (National Relay Service)



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Addendum B – Aetna Medicare Plan (PPO ESA) Service Areas*

Your Aetna Medicare Plan (PPO ESA) is available in all counties within the 50 states, Washington D.C., and the Territories of Puerto Rico, U.S. Virgin Islands and Guam. Below is a list of our network-based service areas

Alabama				
Barbour	Chambers	Dale Henry	Houston Macon	Mobile Russell
Arizona				
Graham	La Paz	Maricopa Pima	Pinal Santa Cruz	Yavapai Yuma
California				
Fresno	Los Angeles	Orange Riverside	San Bernardino San Diego	San Francisco Ventura
Colorado				
Adams	Arapahoe	Boulder Broomfield	Denver Douglas	El Paso Jefferson
Connecticut				
Fairfield	Hartford	Litchfield Middlesex	New Haven New London	Tolland Windham
Delaware				
Kent	New Castle	Sussex		
District of Columbia				
Washington DC				

* Plan members must reside in a plan service area. Aetna Medicare network providers may be located outside of listed plan service areas.



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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

Florida				
Bradford	Collier	Indian River	Miami-Dade	Pinellas
Brevard	DeSoto	Lake	Nassau	Polk
Broward	Duval	Lee	Orange	Saint Johns
Charlotte	Hernando	Manatee	Osceola	Saint Lucie
Citrus	Highlands	Marion	Palm Beach	Sarasota
Clay	Hillsborough	Martin	Pasco	Seminole
				Volusia
Georgia				
Appling	Coweta	Habersham	Marion	Spalding
Baldwin	Crawford	Hall	Meriwether	Stewart
Banks	Crisp	Hancock	McDuffie	Sumter
Barrow	Dawson	Haralson	McIntosh	Talbot
Bartow	DeKalb	Harris	Monroe	Taliaferro
Ben Hill	Dooly	Hart	Morgan	Tattnall
Bibb	Dougherty	Heard	Muscogee	Taylor
Bleckley	Douglas	Henry	Murray	Terrell
Bryan	Echols	Houston	Newton	Tift
Burke	Effingham	Irwin	Oconee	Stephens
Butts	Elbert	Jackson	Oglethorpe	Toombs
Camden	Emanuel	Jasper	Paulding	Towns
Charlton	Evans	Johnson	Peach	Treutlen
Chatham	Fannin	Jones	Pickens	Turner
Chattahoochee	Fayette	Lamar	Pike	Twiggs
Cherokee	Forsyth	Laurens	Polk	Union
Clarke	Franklin	Lee	Putnam	Upson
Clayton	Fulton	Liberty	Quitman	Walton
Clinch	Gilmer	Lincoln	Rabun	Warren
Cobb	Glynn	Long	Randolph	Washington
Coffee	Greene	Lumpkin	Richmond	Wayne
Columbia	Gwinnett	Madison	Rockdale	White
			Schley	Worth
Idaho				
Ada	Canyon			

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

Illinois				
Bond	Ford	Logan	Mercer	St. Clair
Boone	Fulton	McHenry	Monroe	Stark
Bureau	Iroquois	McLean	Morgan	Tazewell
Calhoun	Jersey	Macon	Moultrie	Vermilion
Cook	Kane	Macoupin	Ogle	Warren
DeKalb	Kankakee	Madison	Peoria	Washington
Douglas	Kendall	Marshall	Piatt	White
DuPage	Lee	Mason	Putnam	Will
Edgar	Livingston	Menard	Rock Island	Winnebago
			Sangamon	Woodford
Indiana				
Adams	DeKalb	Jefferson	Newton	Starke
Allen	Fayette	Jennings	Noble	Steuben
Benton	Floyd	Johnson	Ohio	St. Joseph
Blackford	Fountain	Kosciusko	Parke	Switzerland
Boone	Franklin	LaGrange	Porter	Tipton
Brown	Gibson	Lake	Posey	Union
Carroll	Hamilton	LaPorte	Pulaski	Vanderburgh
Cass	Hancock	Madison	Putnam	Wabash
Clark	Harrison	Marion	Randolph	Warren
Clinton	Hendricks	Marshall	Ripley	Warrick
Crawford	Henry	Miami	Rush	Washington
Dearborn	Huntington	Montgomery	Scott	Wells
Decatur	Jasper	Morgan	Shelby	White
				Witley
Iowa				
Johnson	Linn	Polk	Pottawattamie	Scott Story
Kansas				
Franklin	Johnson	Leavenworth	Miami	

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

Kentucky				
Anderson Boone	Carter	Harrison	Lawrence	Pendleton
Bourbon	Clark	Henderson	Madison	Powell
Boyd	Fayette	Henry	Mason	Rowan
Bullitt	Franklin	Jefferson	Meade	Scott
Campbell	Grant	Jessamine	Montgomery	Shelby
Carroll	Greenup	Kenton	Nelson	Spencer
	Hardin	Larue	Oldham	Woodford
Louisiana				
Ascension	East Baton Rouge	Livingston	St. James	St. Mary
Assumption	Iberville	Orleans	St. John the Baptist	St. Tammany
Bossier	Jefferson	St. Bernard	St. Landry	Terrebonne
Caddo	Lafourche	St. Charles	St. Martin	West Baton Rouge
Maine				
Androscoggin	Franklin	Knox	Penobscot	Somerset
Aroostook	Hancock	Lincoln	Piscataquis	Waldo
Cumberland	Kennebec	Oxford	Sagadahoc	York
Maryland				
Anne Arundel	Caroline	Frederick	Kent	St. Marys
Baltimore	Carroll	Garrett	Montgomery	Talbot
Baltimore City	Cecil	Harford	Prince Georges	Washington
Calvert	Dorchester	Howard	Queen Annes	Wicomico
				Worcester
Massachusetts				
Bristol	Essex	Hampden	Norfolk	Suffolk
		Middlesex	Plymouth	Worcester

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

Michigan				
Allegan	Genesee	Kent	Muskegon	Saginaw
Antrim	Gladwin	Leelanau	Newaygo	Sanilac
Arenac	Grand Traverse	Livingston	Oakland	St. Clair
Benzie	Gratiot	Macomb	Oceana	St. Joseph
Branch	Hillsdale	Midland	Ogemaw	Tuscola
Calhoun	Kalamazoo	Missaukee	Otsego	Washtenaw
Clare	Kalkaska	Monroe	Ottawa	Wayne
			Roscommon	Wexford
Mississippi				
DeSoto				
Missouri				
Benton	Cole	Henry	Lincoln	St. Louis City
Boone	Crawford	Hickory	Platte	Stone
Cass	Dade	Jackson	Polk	Warren
Christian	Dallas	Jefferson	Ray	Washington
Clay	Greene	Johnson	St. Charles	Webster
		Lawrence	St. Louis	Wright
Nebraska				
Dodge	Douglas	Lancaster	Sarpy	Washington
Nevada				
Clark	Washoe			
New Jersey				
Atlantic	Cape May	Hudson	Monmouth	Salem
Bergen	Cumberland	Hunterdon	Morris	Somerset
Burlington	Essex	Mercer	Ocean	Sussex
Camden	Gloucester	Middlesex	Passaic	Union
				Warren

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

New Mexico				
Bernalillo	Cibola	Sandoval	Socorro	Torrance Valencia
New York				
Albany	Delaware	Monroe	Putnam	St. Lawrence
Bronx	Dutchess	Nassau	Queens	Steuben
Broome	Greene	New York	Rensselaer	Suffolk
Cayuga	Jefferson	Oneida	Richmond	Sullivan
Chemung	Kings	Onondaga	Rockland	Tioga
Chenango	Lewis	Ontario	Saratoga	Tompkins
Columbia	Livingston	Orange	Schenectady	Ulster
Cortland	Madison	Orleans	Schuyler	Westchester
		Oswego	Seneca	Yates
North Carolina				
Alamance	Cleveland	Guilford	Mecklenburg	Sampson
Alexander	Cumberland	Harnett	Montgomery	Scotland
Alleghany	Davidson	Haywood	Orange	Stanly
Buncombe	Davie	Henderson	Person	Stokes
Burke	Durham	Hoke	Polk	Surry
Cabarrus	Forsyth	Iredell	Randolph	Union
Caldwell	Franklin	Johnston	Richmond	Vance
Caswell	Gaston	Lee	Rockingham	Wake
Catawba	Gates	Lincoln	Rowan	Wilkes
Chatham	Granville	Mcdowell	Rutherford	Wilson Yadkin

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

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

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

Pennsylvania				
Adams	Centre	Forest	Luzerne	Schuylkill
Allegheny	Chester	Franklin	Lycoming	Snyder
Armstrong	Clarion	Fulton	McKean	Somerset
Beaver	Clearfield	Greene	Mercer	Sullivan
Bedford	Clinton	Huntingdon	Mifflin	Susquehanna
Berks	Columbia	Indiana	Monroe	Tioga
Blair	Crawford	Jefferson	Montgomery	Union
Bradford	Cumberland	Juniata	Montour	Venango
Bucks	Dauphin	Lackawanna	Northampton	Warren
Butler	Delaware	Lancaster	Northumberland	Washington
Cambria	Elk	Lawrence	Perry	Wayne
Cameron	Erie	Lebanon	Philadelphia	Westmoreland
Carbon	Fayette	Lehigh	Pike	Wyoming
			Potter	York
Rhode Island				
Bristol	Kent	Newport	Providence	Washington
South Carolina				
Abbeville	Charleston	Chester	Laurens	Spartanburg
Anderson	Cherokee	Greenville	Pickens	Union
				York
Tennessee				
Cheatham	Dickson	Maury	Rutherford	Tipton
Davidson	Fayette	Robertson	Shelby	Trousdale
			Sumner	Williamson

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

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

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2020 Evidence of Coverage for Aetna Medicare Plan (PPO)
 Addendum B: Aetna Medicare Plan (PPO) Service Areas*

Utah				
Box Elder Cache	Davis Duchesne	Morgan Rich	Salt Lake Summit Tooele	Utah Wasatch Weber
Virginia				
Alexandria City Amelia Arlington Botetourt Caroline Charles City Chesterfield Colonial Heights City Craig Danville City Dinwiddie Essex	Fairfax Fairfax City Falls Church City Fauquier Fluvanna Franklin Franklin City Fredericksburg City Gloucester Goochland Grayson Greene Hampton City	Hanover Henrico Henry Hopewell City Isle of Wight James City King and Queen King George King William Lancaster Loudoun Louisa Madison	Manassas City Manassas Park City Martinsville City Mathews Middlesex Nelson New Kent Newport News City Northumberland Petersburg City Pittsylvania Poquoson City Portsmouth City	Powhatan Prince George Prince William Radford City Richmond City Roanoke Roanoke City Salem City Spotsylvania Stafford Sussex Westmoreland Williamsburg City York
Washington				
King	Kitsap	Mason	Pierce	Snohomish Thurston
West Virginia				
Cabell	Kanawha Marion	Marshall Mason	Monongalia Ohio	Putnam Wood
Wisconsin				
Kenosha	Milwaukee	Ozaukee Racine	Sheboygan Walworth	Washington Waukesha

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Nondiscrimination Notice

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Aetna provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters; and written information in other formats (large print, audio, accessible electronic formats, other formats). Aetna also provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. If you need these services, contact the Aetna Medicare Customer Service Department at the phone number on your member identification card.

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).



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, contact the phone number on your member identification card. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance in writing with the 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). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD). 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.

TTY: 711

ENGLISH:

ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at aetnamedicare.com or call the phone number on your member identification card. (English)

ESPAÑOL (SPANISH):

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en aetnamedicare.com o llame al número de teléfono que se indica en su tarjeta de identificación de afiliado.

简体中文(CHINESE):

请注意：如果您说中文，您可以获得免费的语言援助服务。访问我们的网站aetnamedicare.com 或致电您会员卡上的电话号码。

TAGALOG (TAGALOG - FILIPINO):

PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuhang libreng tulong na serbisyo para sa wika. Puntahan ang aming website sa aetnamedicare.com o tawagan ang numero ng telepono sa inyong ID kard ng miyembro.

FRANÇAIS (FRENCH):

ATTENTION : Si vous parlez le français, des services gratuits d'aide linguistique sont disponibles. Visitez notre site Web à l'adresse aetnamedicare.com ou appelez le numéro de téléphone figurant sur votre carte d'adhérent.

TIẾNG VIỆT (VIETNAMESE):

LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin truy cập trang web của chúng tôi tại aetnamedicare.com hoặc gọi số điện thoại ghi trên thẻ chứng minh thành viên của quý vị.

DEUTSCH (GERMAN):

ACHTUNG: Wenn Sie deutsch sprechen, steht ein kostenloser Dolmetscherservice zur Verfügung. Besuchen Sie unsere Website unter aetnamedicare.com oder rufen Sie unter der auf Ihrem Mitgliedsausweis aufgeführten Telefonnummer an.

한국어 (KOREAN):

주의: 한국어를 하시는 분들을 위해 무료 통역 서비스가 제공됩니다. aetnamedicare.com에서 웹사이트를 방문하거나 귀하의 회원 ID 카드에 제공된 전화번호로 문의해 주시기 바랍니다.

РУССКИЙ (RUSSIAN):

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться нашими бесплатными услугами переводчиков. Посетите наш веб-сайт по адресу aetnamedicare.com или позвоните по телефону, указанному на вашей карточке-удостоверении.

العربية (ARABIC):

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية سوف تتوفر لك مجانًا. تفضل بزيارة الموقع الإلكتروني الخاص بنا aetnamedicare.com أو اتصل برقم الهاتف الموجود على بطاقة هوية العضو الخاصة بك.

हिंदी (HINDI):

ध्यान दें: अगर आप बात करने में सक्षम हैं हिंदी, तो निशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट aetnamedicare.com पर विजिट करें या अपने सदस्य पहचान कार्ड पर दिए गए फोन नंबर पर कॉल करें।

ITALIANO (ITALIAN):

ATTENZIONE: Se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Visita il nostro sito web aetnamedicare.com o chiama il numero telefonico riportato sulla tua tessera personale.

PORTUGUÊS (PORTUGUESE):

ATENÇÃO: Se você fala português, serviços gratuitos de ajuda para esse idioma estão disponíveis. Visite nosso site aetnamedicare.com ou ligue para o número listado em seu cartão de identificação de associado.

KREYOL AYISYEN (FRENCH CREOLE):

ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd gratis nan lang ki disponib pou ou. Ale sou sitwèb nou nan aetnamedicare.com oswa rele nimewo telefòn ki nan kat idantifikasyon manm ou.

POLSKI (POLISH):

UWAGA! Osoby mówiące po polsku, mogą skorzystać z bezpłatnych usług pomocy językowej. Proszę wejść na naszą stronę internetową aetnamedicare.com lub zadzwonić pod numer telefonu podany na karcie identyfikacyjnej członka.

日本語 (JAPANESE):

ご注意：日本語を話す方を対象に、無料の言語支援サービスを用意しております。当社ウェブサイト aetnamedicare.com をご覧いただくか、会員カードに記載の電話番号までお電話ください。

SHQIP (ALBANIAN):

KUJDES: Nëqoftëse flisni shqip, shërbimet e ndihmës gjuhësore janë në dispozicion tuaj falas. Vizitoni Faqen tonë të Internetit në adresën: aetnamedicare.com ose telefononi në numrin e telefonit që paraqitet në kartën e identifikimit të anëtarësisë tuaj.

አማርኛ (AMHARIC):





ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የገጸ የቋንቋ እርዳታ አገልግሎቶች ማግኘት ይችላሉ። ድረ ገጻችንን በ aetnamedicare.com ይጎብኙ ወይም በአባልነት መታወቂያዎት ላይ ያለውን ስልክ ቁጥር ይደውሉ።

Հայերեն (ARMENIAN):

Ուշադրություն: Եթե դուք խոսում եք հայերեն, անվճար լեզվական օգնության ծառայությունները հասանելի են: Այցելելք մեր կայքը aetnamedicare.com կամ զանգահարելք հեռախոսահամարը Ձեր անդամ նույնականացման քարտը:



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>AetnaRetireePlans.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.



If you have any questions, please call Customer Service at the telephone number listed on your member ID card.



Inspired by you

Your Medicare Advantage plan handbook



Welcome

We're glad you're a member of our Aetna Medicare plan. We created this handbook with you in mind. That means the whole you — body, mind and spirit. Inside, you'll find useful information and tips to help you make the most of your Medicare plan and continue living the life you love.

Thanks for being a valued member of the Aetna family. We're excited to help you fulfill your health goals.

What's inside?

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Our commitment

At Aetna, our goal is to provide you with the services you need and help you find the right coverage and resources to care for the whole you — body, mind and spirit. Getting the right coverage when you need it can lead to better health. Our total approach to health incorporates three features that are at the core of everything we do.



Guidance and support

Guidance and support can help you achieve your best health. That's why Aetna representatives help simplify Medicare and connect you to the right coverage, resources and care.



For the whole you

Being healthy isn't just eating right and exercising. It's taking care of your mind as well. That's why Aetna Medicare plans may include benefits like fitness memberships and mental wellness programs.



Close to home

Your community impacts your health, and we know the importance of coordinated care, close to home. We support neighborhood health programs and provide you with personalized care, locally.

Getting started

Get off to a great start by following these three easy steps:

1 Log in to the member website

We offer online tools to help guide your health goals. Whether you want to see your member ID card, find providers or view your claims, we've got you covered.

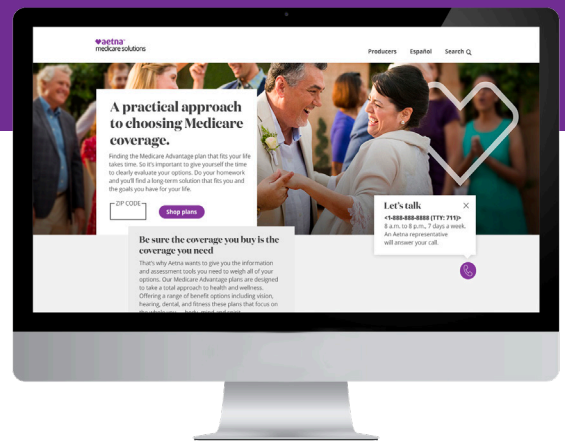
2 Get to know your benefits

You can find complete benefits information for your plan in your Evidence of Coverage (EOC) and Schedule of Cost Sharing. These have detailed information on your coverage, costs and rules you need to follow.

3 Find providers and select a primary care physician (PCP)

It's important to have a solid support system. Your PCP can coordinate your care to help you better manage your health. Check your EOC to see if your plan requires you to have a PCP on file with us, or if you can see providers both in and outside of our network and still be covered. Providers must be eligible to receive Medicare payment and accept your plan.

Please take the primary care checklist at the back of this booklet to your next appointment.



Register for or log in to the member website using your Aetna member ID number at [AetnaRetireePlans.com](https://www.aetna.com/RetireePlans)

Find doctors and hospitals in the Aetna network here:

[AetnaMedicare.com/findprovider](https://www.aetna.com/findprovider)



Urgent vs. emergency care



If you're suddenly sick or injured, your first thought may be to head to the emergency room (ER). However, depending on your medical issue, the ER may not be the best choice. Urgent care facilities can offer a more convenient way to get quick care.

Please note that this is not a complete list of reasons to visit an urgent care center or emergency room. In the event of a medical emergency, call 911 or go to the closest ER.



URGENT CARE CENTER



EMERGENCY ROOM (ER)

	URGENT CARE CENTER	EMERGENCY ROOM (ER)
PURPOSE	These centers offer treatment for non-life-threatening injuries or illnesses	The ER offers treatment for serious injuries or illnesses
ADVANTAGES	Conveniently accepts both walk-ins and appointments, may provide faster treatment, flexible hours	Offers emergency care, treats more serious health issues, open 24/7
SOME CONDITIONS EACH FACILITY TREATS	<ul style="list-style-type: none"> Allergies Coughing Upset stomach Sinus infection Broken bones Sore throat Flu symptoms Pink eye Ear infections Cuts, bumps or sprains 	<ul style="list-style-type: none"> Difficulty breathing Loss of consciousness Severe burns Chest pain or suspected heart attack Severe bleeding Acute stomach pain Poisoning

Extra benefits

AbleTo program

This behavioral health program helps treat depression and anxiety. Your Aetna nurse will coordinate access to licensed therapists and behavior coaches. It includes eight weeks of personalized, structured cognitive behavioral therapy and coaching via secure phone or video.



Healthy home visits

A licensed health care professional can come to your home to review your health needs and do a home safety assessment. During the visit, they may also review your medicines, complete some health screening tests and recommend services that can support your health needs.



Case management

Case management programs are for people who need extra assistance and support. Your case manager will work with you and your doctor to support your care plan.



Discounts

You may have access to discounts on items like weight management programs, medical alert systems and oral health care. For information on available discounts, log in to your member website or call member services.



Resources For Living

Our Resources For Living® program helps get you the right support when and where you need it. It's designed to help you find a wide range of services in your area — from personal care, housekeeping and maintenance to caregiver relief, pet care services and adult day care programs.



To contact our Resources For Living team, call:
1-866-370-4842 (TTY: 711)

24/7 nurse hotline

You can talk to our registered nurses, day or night. They can help you decide if a doctor or urgent care visit is needed, understand your symptoms or learn about treatments.



To speak with a registered nurse anytime, call **1-800-556-1555 (TTY: 711)**

If you need more information about any of our Extra Benefits, call the number on your member ID Card.



Medicare key terms

Coinsurance — This is the amount you may have to pay for your share of services. Coinsurance is usually a percentage (for example, 20 percent).

Copayment (copay) — This is the amount you may have to pay for your share of services. Copays are usually a set amount (for example, \$20 for a doctor visit).

Cost sharing — These are amounts that your plan may require you to pay for your care. Examples of cost sharing can include deductibles, copays or coinsurance.

Deductible — This is the amount some plans require you to pay for covered services before the plan starts to pay.

Explanation of Benefits (EOB) — An EOB is a notice explaining charges, payments or any balances owed after a provider you have visited submits a claim. It may be sent by mail or electronically.

Evidence of Coverage (EOC) — This document gives you detailed information on your plan's coverage, costs and your rights and responsibilities as a plan member.

In network — This means we have a contract with that doctor or other health care provider. We negotiate reduced rates with them to help you save money. Some plans give you access to both in and out-of-network providers, as long as they are eligible to receive Medicare payment and accept your plan. Check your plan documents.

Premium — This is the amount you may pay your plan for coverage.

Urgent care centers — These centers can treat urgent, but non-life-threatening, medical issues. A few examples are sprains, fractures and minor burns. If you have a medical issue that threatens your life, always visit the nearest emergency room or call 911 first.

Primary care checklist

Your path to better health begins with talking to your doctor. Your primary care physician (PCP) can help you build a plan to reach your health goals.

Here's a checklist of important topics you may want to discuss with your PCP. Take this worksheet with you to your next appointment and check the boxes and take notes as you talk about each item.

Remember to call us at the number on your member ID card if you have any questions, need to notify us if you've made an address change or let us know if you would like someone else, like a caregiver, to act on your behalf. Also make sure your former employer/union/trust is aware.

Medical history

Recent health changes

Your major life events

Medicines

Prescriptions: _____

Over the counter: _____

Medicine side effects

Vaccines

Flu shot (date): _____

Pneumonia (date): _____

Screenings

(Blood pressure, cholesterol, colorectal)

Women's health

(Mammogram, pap smear, bone density)

Long-term health conditions

(Diabetes monitoring, kidney function)

Mental health

Fall prevention

Write down any questions you'd like to discuss with your doctor.





Thank you



Thanks again for being a valued member of the Aetna family.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Out-of-network/noncontracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. The member is responsible for the full cost of discounted services. Aetna may receive a percentage of the fee paid to a discount vendor. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2019 Tivity Health, Inc. All rights reserved. Aetna Resources For LivingSM is the brand name used for products and services offered through the Aetna group of subsidiary companies (Aetna). The EAP is administered by Aetna Behavioral Health, LLC. and in California for Knox-Keene plans, Aetna Health of California, Inc. and Health and Human Resources Center, Inc. ©2019 Aetna Inc.