Aetna

Certificate of Coverage

City of Seattle – Retirees

Medicare Open Plan

January 1, 2012

January 1 – December 31, 2012

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

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

A Medicare Advantage organization with a Medicare contract

This information is available for free in other languages. Please contact Member Services at the telephone number printed on the back of your member ID card for additional information. (TTY/TDD users should call 1-888-760-4748.) Hours are 8 a.m. to 8 p.m., 7 days a week. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al número en el dorso de su tarjeta de identificación de miembro. (Los usuarios de TTY/TDD deben llamar al 1-888-760-4748). Nuestro horario de atención es de 8 a.m. a 8 p.m., los siete días de la semana. Las personas que no hablan inglés pueden solicitar el servicio gratuito de intérpretes a Servicios al Cliente.

This document may be made available in other formats such as Braille, large print or other alternate formats. Please contact Member Services for more information.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2013.

2012 Evidence of Coverage

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SECTION 1 Introduction

Section 1.1 You are enrolled in Aetna Medicare Plan (PPO), which is a Medicare PPO

Your coverage is provided through contract with your current employer or 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. Our plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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

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

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

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

Section 1.3 What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- How to pay your plan premium (if applicable)
- How do you keep the information in your membership record up to date?

Section 1.4 What if you are new to our plan?

If you are a new member, then it's important for you to learn how the plan operates – what the 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 Member Services (contact information is on the back of your member ID card).

Section 1.5 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in our plan between January 1, 2012 and December 31, 2012.

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 through our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services 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 live in the plan service area
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B

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

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:
- Medicare Part A generally covers services furnished by institutional providers such as hospitals, 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 and supplies).

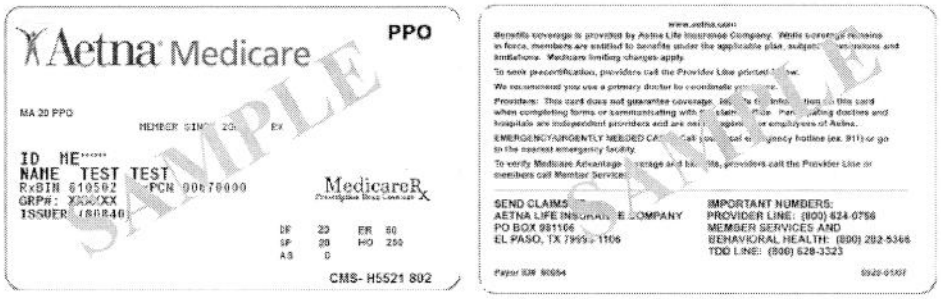
Section 2.3 The plan service area

Although Medicare is a federal program, our plan is available only to individuals who live in our plan service area. To stay a member of our plan, you must keep living in the service area. If you move to outside of the state, please contact Member Services at the telephone number on your member ID card.

SECTION 3 What other materials will you get from us?

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

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



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

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Aetna Medicare 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 Member Services right away and we will send you a new card.

Section 3.2 The *Provider Directory*: Your guide to all providers and pharmacies in the plan's network

Our plan offers an extended service area. Aetna Medicare may or may not have a provider network where you live. Every year that you are a member of our plan and residing in a network service area, we will send you either a Provider Directory or an update to the Provider Directory, which lists our network providers.

What are "network providers"?
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 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 out-of-network providers and 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*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at www.aetnaretireeplans.com, or download it from this website. Both Member Services 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 and willing to accept our plan. To find a provider that participates with Original Medicare, go to www.medicare.gov.

What are "network pharmacies"?
Our *Provider Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?
You can use the *Provider Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Provider Directory*, you can get a copy from Member Services (phone numbers are on the back of your member ID card). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.aetnaretireeplans.com.

Section 3.3 The plan's List of Covered Drugs (Formulary)

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

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

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it. To get

the most complete and current information about which drugs are covered, you can visit the plan's website (www.aetnaretireeplans.com) or call Member Services (phone numbers are on the back of your member ID card).

Section 3.4 The *Explanation of Benefits* (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the "EOB").

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

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

SECTION 4 Your monthly premium for our plan (if applicable)

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

Your coverage is provided through a contract with your current employer or 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 notify you of your plan premium amount before the start of the plan year. If you have an Aetna plan premium and you are not billed directly by Aetna Medicare for this premium, please refer to your plan benefits administrator for any premium payment information.

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

In some situations, your plan premium could be <u>less</u>
There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums that you get from your employer/union/trust benefits administrator may not apply to you**. We send you a separate insert, called the "Evidence of Coverage Rider for People

Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Member Services are on the back of your member ID card.

In some situations, your plan premium could be more

These situations are described below.

- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, you can visit http://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You may also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's standard drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.
  - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 *explains the late enrollment penalty.*
  - If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly plan premium (if applicable). You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called "2012 Medicare Costs." This explains how the Part B premium differs 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 2012* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium (if applicable)

Your coverage is provided through a contract with your current employer or 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 letter 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, including by check, electronic payment or automatic withdrawal. You may inform us of your premium payment option choice or change your choice by calling Member Services at the numbers printed on the back of 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.

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 by the first day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within a three-month period.

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

If we end your membership with the plan because you did not pay your plan premium, then you will not be able to receive Part D coverage until the annual election period. At that time, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a premium penalty when you sign up for a Part D plan.)

If we end your membership because you did not pay your premium, you will have 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 will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you have a right to appeal our decision. For information about how to appeal the termination of coverage, 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 4.3 Can we change your monthly plan premium during the year?

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

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

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If 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 Member Services (phone numbers are on the back of your member ID card).

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 7 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 Member Services (phone numbers are on the back of your member ID card).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 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 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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

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

- If you have retiree coverage, Medicare pays first.

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

  - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.

  - If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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 Member Services (phone numbers are on the back of your member ID card.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 **Aetna Medicare contacts** (how to contact us, including how to reach Member Services at the plan)

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

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

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

SECTION 5 **Social Security**

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

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

SECTION 8 **How to contact the Railroad Retirement Board**

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

SECTION 1 Aetna Medicare contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services
For assistance with claims, billing or member card questions, please call or write to Aetna Medicare Member Services. We will be happy to help you.

Member Services	
CALL	Please call the telephone number printed on the back of your member ID card. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
WRITE	Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088
WEBSITE	www.aetnaretireeplans.com

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

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

Coverage Decisions for Medical Care	
CALL	1-800-282-5366 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who

	have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
WRITE	Aetna Medicare Precertification Unit P.O. Box 14079 Lexington, KY 40512-4079

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

Appeals for Medical Care	
CALL	1-800-932-2159 for Expedited Appeals Only Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
FAX	1-866-604-7092
WRITE	Aetna Medicare Grievance & Appeal Unit P.O. Box 14067 Lexington, KY 40512

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

Complaints about Medical Care	
CALL	1-800-282-5366 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.

TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
FAX	1-866-604-7092
WRITE	Aetna Medicare Grievance & Appeals Unit P.O. Box 14067 Lexington, KY 40512

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

Coverage Decisions for Part D Prescription Drugs	
CALL	1-800-414-2386 Calls to this number are free. Hours of operation: Monday through Friday, 8 a.m. to 8 p.m. Eastern time
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: Monday through Friday, 8 a.m. to 8 p.m. Eastern time.
FAX	1-800-408-2386
WRITE	Pharmacy Management Precertification Unit 300 Highway 169 South, Suite 500 Minneapolis, MN 55426
WEBSITE	www.aetnaretireeplans.com

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

Appeals for Part D Prescription Drugs	
CALL	1-877-235-3755 for Expedited Appeals Only Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
FAX	1-866-604-7092
WRITE	Aetna Medicare Pharmacy Grievance and Appeals Unit P.O. Box 14579 Lexington, KY 40512
WEBSITE	www.aetnaretireeplans.com

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

Complaints about Part D prescription drugs	
CALL	1-800-282-5366 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., 7 days per week.
FAX	1-866-604-7092
WRITE	Aetna Medicare Pharmacy Grievance and Appeal Unit P.O. Box 14579 Lexington, KY 40512

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

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

Payment Requests	
1. **WRITE**	**For Prescription Drug Claims:** Aetna Medicare Prescription Drug Claim Processing Unit P.O. Box 14023 Lexington, KY 40512 **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.

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

	Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites." The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. Select "Find Out if You're Eligible." • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans" or "Compare Medigap Policies." These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. 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 at the number above 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.

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 of 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 Quality Improvement Organization (QIO) in each state. Refer to the Addendum A at the back of this *Evidence of Coverage* for the name of the Quality Improvement Organization in your state.

A 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. A QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in your state 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

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

Social Security Administration	
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 am to 7:00 pm , Monday through Friday.
WEBSITE	http://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 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).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid agency. Contact information is in Addendum A in the back of this *Evidence of Coverage*.

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

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

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

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

- While you are at the pharmacy, you can ask the pharmacist to contact Aetna at the number on your ID card. If the situation cannot be resolved at that time, Aetna will give you a one-time exception and you will be charged the copayment/coinsurance amount that you were given by CMS. This exception is temporary and lasts 21 days. Aetna will permanently update our systems upon the receipt of one of the acceptable forms of evidence listed below. You can fax your evidence to Aetna at 1-888-665-6296, or mail your documentation to:

  Aetna Medicare Department
  Attention: BAE
  P.O. Box 14088
  Lexington, KY 40512-4088

  Examples of evidence can be any of the following items:

  - A copy of your Medicaid card that includes your name and an eligibility date during a month after June of the previous calendar year
  - A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year
  - A print out from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year
  - A screen print from the state's Medicaid systems showing Medicaid status during a month after June of the previous calendar year
  - Other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year
  - For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter
  - If you are institutionalized and qualify for zero cost-sharing:

	Calls to this number are free. Available 7:00 am to 7:00 pm , Monday through Friday.
WEBSITE	http://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)

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In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These 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).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid agency. Contact information is in Addendum A in the back of this *Evidence of Coverage*.

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

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

- While you are at the pharmacy, you can ask the pharmacist to contact Aetna at the number on your ID card. If the situation cannot be resolved at that time, Aetna will give you a one-time exception and you will be charged the copayment/coinsurance amount that you were given by CMS. This exception is temporary and lasts 21 days. Aetna will permanently update our systems upon the receipt of one of the acceptable forms of evidence listed below. You can fax your evidence to Aetna at 1-888-665-6296, or mail your documentation to:

  Aetna Medicare Department
  Attention: BAE
  P.O. Box 14088
  Lexington, KY 40512-4088

  Examples of evidence can be any of the following items:

  - A copy of your Medicaid card that includes your name and an eligibility date during a month after June of the previous calendar year
  - A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year
  - A print out from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year
  - A screen print from the state's Medicaid systems showing Medicaid status during a month after June of the previous calendar year
  - Other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year
  - For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter
  - If you are institutionalized and qualify for zero cost-sharing:

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year

- A copy of a state document that confirms Medicaid payment on your behalf to the facility for a full calendar month after June of the previous calendar year

- A screen print from the state's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year

- CMS and additional SSA documents that supports a beneficiary's LIS cost sharing level:
  - Deeming notice – pub.no. 11166 (purple notice)
  - Auto-enrollment notice – pub.no.11154 (yellow notice)
  - Full-facilitated notice – pub.no. 11186 (green notice)
  - Partial-facilitated notice – pub.no.11191 (green notice)
  - Copay change notice – pub.no.11199 (orange notice)
  - Reassignment notice – pub.no. 11208 and 11209 (blue notice)

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

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

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count

toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 14% of the price for generic drugs and you pay the remaining 86% of the price. The coverage for generic drugs works differently than the 50% discount for brand name drugs. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

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

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?
If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?
No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?
If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Refer to Addendum A at the back of this *Evidence of Coverage* to identify if there is an SPAP in your state.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call that employer/union/trust's benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

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

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

SECTION 1 Things to know about getting your medical care covered as a member of our plan
Section 1.1 What are "network providers" and "covered services"?
Section 1.2 Basic rules for getting your medical care covered by the plan

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
Section 2.2 How to get care from specialists and other network providers
Section 2.3 How to get care from out-of-network providers

SECTION 3 How to get covered services when you have an emergency or urgent need for care
Section 3.1 Getting care if you have a medical emergency
Section 3.2 Getting care when you have an urgent need for care

SECTION 4 What if you are billed directly for the full cost of your covered services?
Section 4.1 You can ask the plan to pay our share of the cost of your covered services
Section 4.2 If services are not covered by our plan, you must pay the full cost

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

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

SECTION 7 Rules for ownership of durable medical equipment
Section 7.1 Will you own your durable medical equipment after making a certain number of payments under our plan?

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

This chapter tells things 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 as your share of the cost when you get this care, use the benefits chart included with this *Evidence of Coverage.* It's described in Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*). **This benefits chart is also referred to as Aetna's *Schedule of Copayments/ Coinsurance.***

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 generally bill us directly for care they give you. When you see a network provider, you usually 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 benefits chart in Chapter 4.

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

As a Medicare health plan, our plan 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 Medical Benefits Chart (Schedule of Copayments/Coinsurance)** included 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.

- **You receive your care from a provider who participates in Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider Directory*.

  - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to 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

When you become a member of our plan, you do not have to choose a plan provider to be your PCP, however we encourage you to do so by contacting Member Services at the number on your plan membership card and designating your choice of a PCP. By having a PCP coordinate your care, you may benefit by receiving care from a doctor that has a deeper understanding of your health care needs and may be able to assist with important medical decisions. A PCP is a physician who meets state requirements and is trained to give you routine medical care. A PCP could provide most of your care and can help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes:

- x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care.

"Coordinating" your services includes referring and consulting with other plan providers about your health care needs. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

How do you choose your PCP?
You may select a network PCP at the time of enrollment or at any other time. You can select a PCP from either the *Provider Directory* or by calling Member Services, anytime, for assistance. You can also select a PCP by accessing our online provider directory, DocFind, at www.aetnaretireeplans.com. If there is a particular plan specialist or hospital that you want to use, check first to be sure that your PCP makes referrals to that specialist, or uses that hospital.

Changing your PCP
You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan.

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or currently getting other covered services that were coordinated by your PCP (such as home health services and durable medical equipment). They will check to see if the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and confirm when the change to your new PCP will take effect. The PCP change is effective on the day you make your change request.

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, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who 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 specialist. If you do choose to use a PCP, when your PCP thinks you may need specialized treatment, your PCP will direct you to see a network plan specialist or other health care provider or facility.

For certain types of covered services or supplies, your PCP or other network provider will need to get prior authorization (prior approval) from Aetna. These covered services are marked on the Benefits Chart included with this *Evidence of Coverage*.

What if a specialist or another network provider leaves our plan?
Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If your PCP is terminating from the Aetna Medicare network, we will make a best effort to notify you in writing 30 days in advance of the PCP termination effective date. If a hospital, specialist or other type of participating network provider is terminating from the Aetna Medicare network, we will make a best effort to provide written notification 30 days in advance of the provider's termination effective date to all members who have received services from the terminating provider at least twice in the last 12 months. You may contact Member Services at the number on your ID card for assistance in selecting a new PCP or to identify other Aetna Medicare participating providers. You may also look up participating providers using DocFind, available on our website: www.aetnaretireeplans.com.

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. Our plan will cover services from either in-network or out-of-network providers, as long as the

services are covered benefits and are medically necessary. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, that provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

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

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, hospital, or urgent care center. 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 Member Services at the number on your 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 emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart 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 Chapter 4 for more information.

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 if you get the care from network providers or out-of-network providers.

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

What is "urgently needed care"?
"Urgently needed care" is a 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 (for example, a flare-up of a chronic skin condition).

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.

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?
When you are outside the service area, our plan covers urgently needed care you receive from network or out-of-network providers at the same cost sharing amount.

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

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

Section 4.1 You can ask the plan to pay our share of the cost of your covered services

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

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is 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. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the back of your member ID card to get more information about how to do this.

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. Paying for costs once a benefit limit has been reached will not count toward an out-of-pocket maximum limit. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

A clinical research study 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.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Services (see Chapter 2, Section 1 of this *Evidence of Coverage*).

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

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

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

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 would be only $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

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

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

- 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 condition would usually 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 (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. 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 your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.

- If you get services from this institution that are provided to you in a facility, the following condition applies:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

Medicare Inpatient Hospital coverage limits apply; see the Benefits Chart included with this *Evidence of Coverage*.

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call

Member Services (phone numbers are on the back of 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 have made for durable medical equipment if you switch to Original Medicare?

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these new 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the new 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

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

SECTION 1 Understanding your out-of-pocket costs for covered services
Section 1.1 Types of out-of-pocket costs you may pay for your covered services
Section 1.2 What is your yearly plan deductible?
Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?
Section 1.4 Our plan does not allow providers to "balance bill" you

SECTION 2 Use the *Medical Benefits Chart* (also referred to as Aetna's Schedule of Copayments/Coinsurance) to 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

SECTION 3 What benefits are not covered by the plan?
Section 3.1 Benefits we do *not* cover (exclusions)

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 the Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of our plan. The Medical Benefits Chart is included with and is part of this *Evidence of Coverage*. (This benefits chart is also referred to as Aetna's Schedule of Copayments/Coinsurance.) Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations 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 annual 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 Medical Benefits Chart in Section 2 tells you more about your copayments.)

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

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2 What is your annual plan deductible?

Your plan may include a deductible amount for services received from both in-network providers and out-of-network providers. This is the amount you have to pay out-of-pocket before our plan pays its share for your covered medical services. Please refer to the first page of your Medical Benefits Chart (Schedule of Copayments/Coinsurance) for your applicable deductible amount.

Until you have paid the applicable deductible amount, you must pay the full cost of your covered services received from out-of-network providers. Once you have paid your deductible, we will 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. This means that we will pay our share of the costs for these services even if you haven't paid your yearly deductible yet. The deductible does not apply to the following services: emergency ambulance transport, emergency care, urgent care, Welcome to Medicare physical exam, annual wellness visit, preventive care, Medicare Part B prescription drugs, and eyewear or hearing aid reimbursements if included in your plan. Your plan may include additional services that do not apply to the deductible. Refer to the Medical Benefits Chart included with this *Evidence of Coverage* for a full list of services that are not subject to the plan deductibles.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount.** This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from in-network providers. The amounts you pay for copayments and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid the maximum out-of-pocket amount for covered Part A and Part B services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount.** This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your 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 Medical Benefits Chart.) 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 Part A and Part B services. However, you must continue to pay your plan premium 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, you only have to pay the plan's cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as "balance billing." This protection (that you never pay more than the plan 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, $15.00), then you pay only that amount for any services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.

- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate (including Limiting Charge) for non-participating providers.

SECTION 2 Use the Medical Benefits Chart (also referred to as Aetna's Schedule of Copayments/Coinsurance) to 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 Medical Benefits Chart (Schedule of Copayments/Coinsurance) included with this *Evidence of Coverage* lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.

- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your network doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Aetna Medicare.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk and footnote in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

- 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 obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate (including Limiting Charge) for non-participating providers.

- 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 cost sharing amount may apply for the care received for the existing medical condition.

See the Medical Benefits Chart (also referred to as Aetna's Schedule of Copayments/ Coinsurance) included with this *Evidence of Coverage* for details.

SECTION 3 What benefits are not covered by the plan?

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

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) 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.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses unless purchased as additional plan coverage by your employer/union/trust group plan.
- 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, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.

- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines, unless purchased as additional plan coverage by your employer/union/trust group plan.
- Orthopedic shoes, unless the 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, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids or exams to fit hearing aids, unless listed on the Benefits Chart.
- Eyeglasses, routine eye examinations (unless listed in the Benefits Chart), radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).

- Services provided to veterans in Veterans Affairs (VA) facilities. However, 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.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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

SECTION 1 Introduction
Section 1.1 This chapter describes your coverage for Part D drugs
Section 1.2 Basic rules for the plan's Part D drug coverage

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service
Section 2.1 To have your prescription covered, use a network pharmacy
Section 2.2 Finding network pharmacies
Section 2.3 Using the plan's mail-order services
Section 2.4 How can you get a long-term supply of drugs?
Section 2.5 When can you use a pharmacy that is not in the plan's network?

SECTION 3 Your drugs need to be on the plan's "Drug List"
Section 3.1 The "Drug List" tells which Part D drugs are covered
Section 3.2 There are five "cost-sharing tiers" for drugs on the Drug List
Section 3.3 How can you find out if a specific drug is on the Drug List?

SECTION 4 There are restrictions on coverage for some drugs
Section 4.1 Why do some drugs have restrictions?
Section 4.2 What kinds of restrictions?
Section 4.3 Do any of these restrictions apply to your drugs?

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?
Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered
Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

SECTION 6 What if your coverage changes for one of your drugs?
Section 6.1 The Drug List can change during the year
Section 6.2 What happens if coverage changes for a drug you are taking?

SECTION 7 What types of drugs are *not* covered by the plan?
Section 7.1 Types of drugs we do not cover

SECTION 8 Show your plan membership card when you fill a prescription
Section 8.1 Show your membership card
Section 8.2 What if you don't have your membership card with you?

SECTION 9 Part D drug coverage in special situations

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

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

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

Section 10.2 Programs to help members manage their medications

? **Did you know there are programs to help people pay for their drugs?**
There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?
If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Member Services are on the back of your member ID card.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

In addition to your coverage for Part D drugs, our plan also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. The Medical Benefits Chart included with this *Evidence of Coverage* tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The Medical Benefits Chart included with this *Evidence of Coverage* tells about your benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits. **This chapter explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

Section 1.2 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor or other prescriber) write your prescription.

- You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?
To find a network pharmacy, you can look in your *Provider Directory*, visit our website (www.aetnaretireeplans.com) or call Member Services (phone numbers are on the back of your member ID card). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?
If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the back of your member ID card) or use the *Provider Directory*. You can also find information on our website at www.aetnaretireeplans.com.

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

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

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

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

Section 2.3 Using the plan's mail-order services

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

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

To get order forms and information about filling your prescriptions by mail from our preferred mail order pharmacy, contact Member Services. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 7 to 10 days. In the unlikely event that there is a significant delay with your mail-order prescription drug, our mail-order service will work with you and a network pharmacy to provide you with a temporary supply of your mail-order prescription drug.

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

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of "mail-order" drugs on our plan's Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of mail-order drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Member Services for more information.

2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs available through our plan's mail-order service are marked as **"mail-order" drugs** in our Drug List. Our plan's mail-order service requires you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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

Your prescription may be covered in certain situations
We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.

- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).

- If you are traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.

- If you receive a Part D prescription drug, dispensed by an out-of-network institutional-based pharmacy, while you are in the emergency department, provider-based clinic, outpatient surgery or other outpatient setting.

- If you have not received your prescription during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence.

In these situations when you are covered to fill your prescription at an out-of-network pharmacy, you may be limited to a 10-day supply of your drug.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?
If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

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

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

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)

- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

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

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

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

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

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

The tier structure for your plan and the amount you pay for covered prescription drugs is outlined in the Prescription Drug Benefits Chart (also referred to as the Aetna Schedule of Copayments/Coinsurance) attached to this Evidence of Coverage. Your tier structure will be one of the following:

One Tier Plan
- Tier 1 generic and brand drugs

Two Tier Plan
- Tier 1 generic drugs
- Tier 2 brand drugs

Two Tier with Specialty Plan
- Tier 1 generic drugs
- Tier 2 brand drugs
- Tier 3 specialty tier drugs

Three Tier Plan
- Tier 1 generic drugs
- Tier 2 preferred brand drugs
- Tier 3 non-preferred brand drugs

Four Tier Plan
- Tier 1 generic drugs
- Tier 2 preferred brand drugs
- Tier 3 non-preferred brand drugs
- Tier 4 specialty tier drugs

Five Tier Plan
- Tier 1 preferred generic drugs
- Tier 2 non-preferred generic drugs
- Tier 3 preferred brand drugs
- Tier 4 non-preferred brand drugs
- Tier 5 specialty tier drugs

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

The amount you pay for drugs in each cost-sharing tier is shown in the Prescription Drug Benefits Chart (also referred to as the Aetna Schedule of Copayments/Coinsurance) included with this Evidence of Coverage.

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

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it.)

2. Visit the plan's website (www.aetnaretireeplans.com). The Drug List on the website is always the most current.

3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the back of your member ID card.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 5.2 for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available
Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide**

you the generic version. We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

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

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

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

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the back of your member ID card) or check our website (www.aetnaretireeplans.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

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

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

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.

- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of a number of different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

If your drug is not on the Drug List or is restricted, here are things you can do:

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

- You can change to another drug.

- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply
Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

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

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is **no longer on the plan's Drug List**.
   - -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

2. **You must be in one of the situations described below:**
   - **For those members who were in the plan last year and aren't in a long-term care facility:**
     We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

   - **For those members who are new to the plan and aren't in a long-term care facility:**
     We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

   - **For those members who are new to the plan and reside in a long-term care facility:**
     We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

   - **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**
     We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **Current members with a level of care changes:** if outside a transition of coverage period (at any time during the year), current members will receive up to a 31-day prescription transition fill when they experience a change in their level of care.

To ask for a temporary supply, call Member Services (phone numbers are on the back of your member ID card).

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

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

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug
If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

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

If you and your provider want to ask for an exception, Chapter 9, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- **Move a drug to a higher or lower cost-sharing tier.**

- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).

- **Replace a brand name drug with a generic drug.**

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

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

How will you find out if your drug's coverage has been changed?
If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

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

Do changes to your drug coverage affect you right away?
If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.

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

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

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

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

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

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (except for certain excluded drugs covered under our enhanced drug coverage that may be offered under your plan). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 5.5 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

- Our plan cannot cover a drug purchased outside the United States and its territories.

- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

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

- Non-prescription drugs (also called over-the-counter drugs)

- Drugs when used to promote fertility

- Drugs when used for the relief of cough or cold symptoms

- Drugs when used for cosmetic purposes or to promote hair growth

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject

- Drugs when used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

- Barbiturates and benzodiazepines

Your previous employer/union/trust may offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. If included, this will be identified in your Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) under the section "Enhanced Drug Benefit." The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage.

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to your formulary or call Member Services for more information.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what

drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Addendum A at the end of this booklet.)

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

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

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

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

SECTION 9 Part D drug coverage in special situations

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

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

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

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

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services.

What if you're a resident in a long-term care facility and become a new member of the plan?
If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from another employer/union/trust or retiree group plan?

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

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':
If you are covered by another employer/union/trust retiree group plan, each year that employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

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

Keep these notices about creditable coverage, because you may need them later. If you enroll in a different Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable

coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

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

Section 10.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are on the back of your member ID card).

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

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

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug
Section 2.1 What are the drug payment stages for Aetna Medicare plan members?

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in
Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")
Section 3.2 Help us keep our information about your drug payments up to date

SECTION 4 During the Deductible Stage (if applicable), you pay the full cost of your drugs
Section 4.1 You stay in the Deductible Stage until you have paid any applicable cost sharing

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share
Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription
Section 5.2 Refer to your Prescription Drug Benefits Chart for a table that shows your costs for a *one-month* supply of a drug
Section 5.3 Refer to your Prescription Drug Benefits Chart for a table that shows your costs for a *long-term* (up to a 90-day) supply of a drug
Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach the initial coverage limit

SECTION 6 During the Coverage Gap Stage, our plan may provide some coverage, or you receive a discount on brand name drugs and pay no more than 86% of the costs for generic drugs
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SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs
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SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

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SECTION 9 Do you have to pay the Part D "late enrollment penalty"?

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Section 10.1 Who pays an extra Part D amount because of income?

Section 10.2 How much is the extra Part D amount?

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

? **Did you know there are programs to help people pay for their drugs?**
There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?
If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Member Services are on the back of your member ID card.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by our plan if your former employer has purchased an Enhanced Drug Benefit.

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

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the plan's "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are on the back of your member ID card). You can also find the Drug List on our website at www.aetnaretireeplans.com. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Provider Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Provider Directory* has a list of pharmacies in the plan's network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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

Section 2.1 What are the drug payment stages for Aetna Medicare plan members?

As shown in the table on the next page, there are "drug payment stages" for your prescription drug coverage under your plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
The amount you pay during these stages is listed in the Prescription Drug Benefits Chart (Schedule of Copayments/ Coinsurance) included with this *Evidence of Coverage*.			
If your plan has a deductible, during this stage **you pay the full cost** of your drugs. You stay in this stage until you have paid the amount of your plan's deductible). (Details are in Section 4 of this chapter.)	After you (or others on your behalf) have met your plan deductible (if applicable), the plan pays its share of the costs of your drugs and you pay your share. You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total the amount of your initial coverage limit. (Details are in	During this stage, you will pay 50% of the price (plus the dispensing fee) for brand name drugs and 86% of the price for generic drugs if your plan does not include supplemental coverage. If your plan includes supplemental coverage for generic drugs, you will pay the applicable tier's cost sharing for these drugs. If your plan includes supplemental coverage for brand	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2012). (Details are in Section 7 of this chapter.)

	Section 5 of this chapter.)	drugs, you will receive a discount after the plan's benefit is applied. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $4,700. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	

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

Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB")

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

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

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the back of your member ID card). Be sure to keep these reports. They are an important record of your drug expenses.

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

Section 4.1 You stay in the Deductible Stage until you have paid any applicable cost sharing

The Deductible Stage is the first payment stage for your drug coverage. Your plan's deductible amount (if applicable) is listed on the Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included with this Evidence of Coverage. **You must pay the full cost of your drugs** until you reach the plan's deductible amount.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.

- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

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

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

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

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

The plan has a number of cost-sharing tiers
Every drug on the plan's Drug List is in one of a number of cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug. The tier structure for your plan is listed on the Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included with this *Evidence of Coverage*.

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

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

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

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

Section 5.2 Refer to your Prescription Drug Benefits Chart for a table that shows your costs for a *one-month* supply of a drug

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

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.
- As shown in the table in the Prescription Drug Benefits chart (Schedule of Copayments/ Coinsurance) included with this Evidence of Coverage, the amount of the copayment or coinsurance depends on which tier your drug is in. Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 3.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Section 5.3 Refer to your Prescription Drug Benefits Chart for a table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

As shown in the table in the Prescription Drug Benefits chart (Schedule of Copayments/ Coinsurance) included with this Evidence of Coverage, the amount of the copayment or coinsurance depends on which tier your drug is in.

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

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach the initial coverage limit

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **initial coverage limit for the Initial Coverage Stage**. This amount is listed on the Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included with this Evidence of Coverage.

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

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $2,930 limit in a year.

We will let you know if you reach this $2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, our plan may provide some coverage, or you receive a discount on brand name drugs and pay no more than 86% of the costs for generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,700

The amount of your cost sharing during the Coverage Gap Stage is shown on the Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included with this Evidence of Coverage.

Brand drugs during the Coverage Gap Stage:
When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. If your plan does not include supplemental coverage for brand drugs you pay 50% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap. If your plan does include supplemental coverage for brand drugs, the discount will be applied after your plan benefits have been determined.

Generic drugs during the Coverage Gap Stage:
You also receive some coverage for generic drugs. If your plan does not include supplemental coverage for generic drugs, you pay no more 86% of the cost for generic drugs and the plan pays

the rest. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. If your plan does include supplemental coverage for generic drugs, you will pay the applicable plan copay for the cost sharing tier, and the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and the applicable cost sharing of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2012, that amount is $4,700.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,700, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

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

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

*When you add up your out-of-pocket costs, you **can** **include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (if applicable).
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.

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

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.

- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:
When you (or those paying on your behalf) have spent a total of $4,700 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

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

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

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the back of your member ID card).

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

- **We will help you**. The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $4,700 in out-of-pocket costs for the year, this report

will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

The amount you pay during the Catastrophic Coverage Stage is shown on the Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance.)

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

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

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

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.

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

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

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay).*

   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*

2. **Where you get the vaccine medication.**

3. **Who gives you the vaccination shot.**

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

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

- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

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

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

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.

- Our plan will pay for the cost of giving you the vaccination shot.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.

- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

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

- You will have to pay the pharmacy the amount of coinsurance or copayment for the vaccine itself.

- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.

- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Section 8.2 You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers are on the back of your member ID card).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.

- We can tell you how to keep your own cost down by using providers and pharmacies in our network.

- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D "late enrollment penalty"?

Section 9.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty is added to your monthly premium. Your late enrollment penalty is considered part of your plan premium. If you do not pay your late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Section 9.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2012, this average premium amount is $31.08.

- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $31.08, which equals $4.35. This rounds to $4.40. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

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

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.

- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.

- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in

a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

- For additional information about creditable coverage, please look in your *Medicare & You* 2012 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.

- If you are receiving "Extra Help" from Medicare.

Section 9.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services at the number on the back of your member ID card to find out more about how to do this.

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

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

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

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra

amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

Section 10.2 How much is the extra Part D amount?

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

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

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$11.60
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$29.90
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$48.10
Greater than $214,000	Greater than $129,000	Greater than $428,000	$66.40

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

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

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs
Section 1.1 If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

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

SECTION 3 We will consider your request for payment and say yes or no
Section 3.1 We check to see whether we should cover the service or drug and how much we owe
Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

SECTION 4 Other situations in which you should save your receipts and send copies to us
Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

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

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

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

1. **When you've received medical care from a provider who is not in our plan's network**
   When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. 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. 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.

However, if a network provider has directed you to see an out-of-network provider for specialty care not available from an in-network provider, you should follow the same steps described above to request our plan to pay you back or to pay a bill you have received.

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.
- 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 past. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.
- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

4. **When you use an out-of-network pharmacy to get a prescription filled**
If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section. 2.5 to learn more.)
- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. **When you pay the full cost for a prescription in other situations**
You may pay the full cost of the prescription because you find that the drug is not covered for some reason.
   - For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

Section 2.1 How and where to send us your request for payment

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.

For prescription drug claims, 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 (www.aetnaretireeplans.com) or call Member Services and ask for the form. The phone numbers for Member Services are on the back of your member ID card.

- Mail to us at: Aetna Pharmacy Management
  Attn: Medicare Processing
  P.O. Box 14023
  Lexington, KY 40512-4023

For medical claims, mail your request for payment together with any bills or receipts to us at:

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

Please be sure to contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)

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

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

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

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

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

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

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

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

1. **When you buy the drug for a price that is lower than our price**
   Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.
   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.

   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.

   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

   - **Please note:** If you are in the Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

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

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

Chapter 8. Your rights and responsibilities

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.)

Debemos proveer información en un formato que sea adecuado para usted (en idiomas distintos del utilizado en este folleto, en braille, en letra grande u otros formatos alternativos, etc.)

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

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

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

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

Section 1.6 We must support your right to make decisions about your care

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

Section 1.9 How to get more information about your rights

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

Section 2.1 What are your responsibilities?

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

Debemos proveer información en un formato que sea adecuado para usted (en idiomas distintos del utilizado en este folleto, en braille, en letra grande u otros formatos alternativos, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are on the back of your member ID card).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

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

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

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

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

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

You have the right to choose a provider for your care.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

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

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

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

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the back of your member ID card).

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

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 Member Services (phone numbers are on the back of your member ID card):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

  - For a list of the providers and pharmacies in the plan's network, see the *Provider Directory*.

  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the back of your member ID card) or visit our website at www.aetnaretireeplans.com.

- **Information about your coverage and rules you must follow in using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.

- To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

- If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back of your member ID card).

- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

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

You have the right to get full information from your doctors and other health care providers 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.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

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 Member Services to ask for the forms (phone numbers are on the back of your member ID card).

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your state's Department of Health.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, 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 Member Services (phone numbers are on the back of your member ID card).

Section 1.8 What can you do if you think 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 think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

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

- You can **call Member Services** (phone numbers are on the back of your member ID card).

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are on the back of your member ID card).

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.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 Member Services (phone numbers are on the back of your member ID card). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** *Use this* Evidence of Coverage *booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- ***If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Member Services to let us know.*
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug

benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care or Part D prescription drugs.*

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*

- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells about what you must pay for your medical services. Chapter 6 tells about what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.

- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back of 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 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.

- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan, including our Member Rights and Responsibilities.*
  - Phone numbers and calling hours for Member Services are on the back of your member ID card.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

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

BACKGROUND

SECTION 1 Introduction
Section 1.1 What to do if you have a problem or concern
Section 1.2 What about the legal terms?

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

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?

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
Section 4.2 How to get help when you are asking for a coverage decision or making an appeal
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SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal
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
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)
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)
Section 5.4 Step-by-step: How to make a Level 2 Appeal
Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal
Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug
Section 6.2 What is an exception?
Section 6.3 Important things to know about asking for exceptions
Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
Section 6.6 Step-by-step: How to make a Level 2 Appeal

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon
Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
Section 8.2 We will tell you in advance when your coverage will be ending
Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time
Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

SECTION 9 Taking your appeal to Level 3 and beyond
Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals
Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns
Section 10.1 What kinds of problems are handled by the complaint process?
Section 10.2 The formal name for "making a complaint" is "filing a grievance"
Section 10.3 Step-by-step: Making a complaint
Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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 making 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.

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 (http://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 making appeals."**	**No.** My problem is <u>not</u> about benefits or coverage. Skip ahead to **Section 10** at the end of this

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
	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 making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions
A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You 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 or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

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

When you make an appeal, we review the coverage decision we have 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.

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 several more 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 Member Services** (phone numbers are on the back of 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 or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider 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 Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

If you're not sure which section you should be using, please call Member Services (phone numbers are on the back of 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 (but does not cover Part D drugs, please see Section 6 for Part D drug appeals). These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
   - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
     - Chapter 9, Section 7: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.
     - Chapter 9, Section 8: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
   - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

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

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms	When a coverage decision involves your medical care, it is called an **"organization determination."**

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 decision**."

Legal Terms	A "fast 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 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 decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.

  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for coverage for medical care *you have not yet received.* (You cannot get a fast decision if your request is about payment for medical care you have already received.)

  - You can get a fast 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 decision," we will automatically agree to give you a fast decision.**

- If you ask for a fast decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast 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 decision, we will automatically give a fast decision.

- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.

  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.

  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **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 decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.

  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the

process for making complaints, including fast complaints, see Section 10 of this chapter.)

- If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

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 your 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 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 signed 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 Member Services and ask for the

"Appointment of Representative" form. It is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.

- **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. We are allowed to charge a fee for copying and sending this information to you.
  - 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 decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)

- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.

- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

Section 5.4 Step-by-step: How to make a Level 2 Appeal

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 first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

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

- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

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

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.

- **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.")
  - The written notice you get from the Independent Review Organization will tell you the dollar amount that must be in dispute to continue with the appeals process. For example, to continue and 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.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

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 (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request
- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)

- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (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 part 5.3 of this section. Go to this part 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 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and the use of the drug is a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.

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

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

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

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

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

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

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

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

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the "Drug List" for short.)

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

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

- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

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

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

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

- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

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

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

- If your plan contains both preferred and non-preferred drug tiers, you can ask us to make a tiering exception. If your drug is in the cost-sharing tier for non-preferred generic drugs, you can ask us to cover it at the cost-sharing amount that applies to preferred generic drugs. If your drug is in the cost-sharing tier for non-preferred brand name drugs, you can ask us to cover it at the cost-sharing amount that applies to preferred brand name drugs. This would lower your share of the cost for the drug.

- You cannot ask us to change the cost-sharing tier for any drug in the specialty drug cost-sharing tier (if applicable to your plan).

Section 6.3 Important things to know about asking for exceptions

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

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

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

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

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "**fast decision.**" **You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do
- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to*

contact us when you are asking for a coverage decision about your Part D prescription drugs. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a "fast decision"

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)

  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**

- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).

  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.

  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our 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, see Section 10 of this chapter.)

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

*Deadlines for a **"fast"** coverage decision*

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we

receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

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

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*

- **If you are asking for a standard appeal, make your appeal by submitting a written request.**

- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).

- **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 in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms	A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in Section 6.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the

rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

*Deadlines for a **"fast" appeal***

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.

  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

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

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

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

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

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**

- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"fast" appeal** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."

- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for **"standard" appeal** at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.

- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?
If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

- The Level 3 Appeal is handled by an Administrative Law Judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, see the Medical Benefits Chart (Schedule of Copayments/Coinsurance included with this *Evidence of Coverage*. For information on any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date.**" Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your 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 Member Services. 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.)

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 2 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 Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your 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 Member Services (phone numbers are on the back of 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.

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

Legal Terms	A "fast review" is also called an **"immediate review."**

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.**"

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 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 Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

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 hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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 we turn 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 when 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.

Step 3: Within 14 calendar days, 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 hospital care for as long as it is medically necessary.**

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

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

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

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

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 our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan 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 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 hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

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 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

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

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

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

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

Section 8.1 *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 12, *Definitions of important words.*)

- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words.*)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

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

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a letter or 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.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage.**" To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at http://www.cms.hhs.gov/BNI/

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.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back of 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 in 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 to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

Legal Terms	This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care.

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.

- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

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 we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

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

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited appeal"**.

Step 1: Contact our plan 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 our plan 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. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

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 have told you and we will not pay after this date. We will stop paying our share of the costs of this care.

- 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 ends, then **you will have to pay the full cost** of this care yourself.

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

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 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that

decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

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

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the

notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	**The Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals 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 Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug 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 who works for the federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	**The Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

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

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- 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

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?
    - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- 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?

The next page has more examples of possible reasons for making a complaint

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If

If you have any of these kinds of problems, you can "make a complaint"

you think we are not meeting these deadlines, you can make a complaint.

- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	•	What this section calls a **"complaint"** is also called a **"grievance."**
	•	Another term for **"making a complaint"** is **"filing a grievance."**
	•	Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 10.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call the number on the back of your member ID card (TTY/TDD users call: 1-888-760-4748.) Hours of operation: are 8 a.m. to 8 p.m. in all time zones, 7 days a week.

- **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.

- **If you want to use this process, here's how it works:**
  - Send your written complaint to:

    Aetna Medicare Grievance & Appeal Unit
    P.O. Box 14067
    Lexington, KY 40512

    Be sure to provide all pertinent information. The grievance must be submitted within 60 days of the event or incident. Your issue will be investigated by a grievance analyst who did not have any previous involvement with your issue. A written notice, stating the result of our review will be sent to you. This notice will include a description of our understanding of your grievance, and our decision in clear terms. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for an

extension or if we identify a need for additional information and the delay is in your best interest.

- You also have the right to ask for a fast "expedited" grievance. An expedited or "fast" grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a "fast" grievance if you disagree with:
  - Our plan to take a 14-day extension on an organization determination or reconsideration, or
  - Our denial of your request to expedite an organization determination or reconsideration for health services, or
  - Our denial of your request to expedite a coverage determination or redetermination for a prescription drug.
- The expedited/fast grievance process is as follows: You or an authorized representative may call, fax, or mail your complaint and mention that you want the fast, or expedited, grievance process. Call 1-800-282-5366, fax your complaint to 1-866-604-7092, or write your complaint and send it to the address shown in the paragraph above. 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 Member Services 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 response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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 end 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.

Chapter 10. Ending your membership in the plan

SECTION 1 Introduction
Section 1.1 This chapter focuses on ending your membership in our plan

SECTION 2 When can you end your membership in our plan?
Section 2.1 You can end your membership during the Annual Enrollment Period
Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited
Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period
Section 2.4 Where can you get more information about when you can end your membership?

SECTION 3 How do you end your membership in our plan?
Section 3.1 Usually, you end your membership by enrolling in another plan

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan
Section 4.1 Until your membership ends, you are still a member of our plan

SECTION 5 Aetna Medicare must end your membership in the plan in certain situations
Section 5.1 When must we end your membership in the plan?
Section 5.2 We cannot ask you to leave our plan for any reason related to your health
Section 5.3 You have the right to make a complaint if we end your membership in our plan

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 any time. There are also certain specific times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends.

It is important that you consult with your plan benefits administrator *before* dropping your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

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

Because you are enrolled in our plan through your former employer/union/trust, some of the information in this chapter does not apply to you, because you are allowed to make plan changes at times permitted by your plan sponsor. However, if you ever choose to discontinue your group retiree health plan coverage, the information in this chapter will apply to you.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All Medicare beneficiaries have the opportunity to leave the plan during Medicare's Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Because of your special situation (enrollment through your former employer/union/trust's group plan) you are eligible to end your membership at any time through a Special Enrollment Period (see Section 2.3).

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

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7 in 2011.

- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

It is important that you consult with your plan benefits administrator before dropping your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.

- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.

- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

It is important that you consult with your plan benefits administrator before dropping your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

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

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If you are eligible for Extra Help with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
  - Because you are enrolled in an employer's/union's/trust's group 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.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back of your member ID card).
- You can find the information in the ***Medicare & You 2012*** 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 (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

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

- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

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

If you would like to switch from our plan to:	This is what you should do:
• An individual Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan offered through your employer/union/trust when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan offered through your employer/union/trust when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to

If you would like to switch from our plan to:	This is what you should do:
• **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty.	do this (phone numbers are on the back of your member ID card). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

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

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Aetna Medicare must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Aetna Medicare must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.

- If you move out of our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- 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.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums (if applicable) for three months.
    - We must notify you in writing that you have three months to pay the plan premium before we end your membership.
    - If you have Medicaid or receive Extra Help in paying for your Medicare prescription drugs and are having difficulty paying your plan premiums or cost sharing, please contact us.

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 **Member Services** for more information (phone numbers are on the back of your member ID card).

Section 5.2 We cannot 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 make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Chapter 11. Legal notices

SECTION 1 Notice about governing law

SECTION 2 Notice about nondiscrimination

SECTION 3 Notice about binding arbitration

SECTION 4 Notice about subrogation and right of recovery

SECTION 5 Notice about recovery of overpayments

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. 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, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about binding arbitration

Binding arbitration is the final and exclusive process for resolving any dispute between a member and the Plan, other than those brought under the Medicare Appeals Procedure. All interested parties are giving up their constitutional right to have their dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

The agreement to arbitrate includes bad faith claims and disputes that relate to professional liability or medical malpractice.

This Evidence of Coverage also limits certain remedies such as:

- No jury trial: In any dispute arising from or related to coverage, there shall be no right to a jury trial. This right to trial is waived.

- Medical malpractice claims: Any claim alleging wrongful acts or omissions of participating providers will not include the Aetna Medicare plan and will only include the participating provider subject to this allegation. Members waive their right to bring any claim against Aetna as a party to this claim.

- Class actions: Members cannot participate in a representative capacity as a member of any class actions relating to plan coverage. Claims brought by members may not be joined or consolidated with claims brought by another member, unless agreed to in writing by Aetna.

Unless otherwise agreed by the parties to the arbitration, all disputes shall be submitted to neutral arbitration within the Aetna Service Area to the American Arbitration Association (AAA) or such other neutral dispute resolution organization as mutually agreed by the parties. The AAA

can be reached by calling 1-800-778-7879. For additional information on the arbitration process, contact Member Services at the telephone number on your ID card.

SECTION 4 Notice about subrogation and right of recovery

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 www.medicare.gov web site.

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 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 5 Notice about recovery of overpayments

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

Chapter 12. Definitions of important words

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 beneficiaries can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011. Your employer/union/trust may have an Annual Enrollment Period that differs.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of our plan, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.4 for more information about balance billing.

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

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,700 in covered drugs during the covered year.

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

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. 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 Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

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 – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible

for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care 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.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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.

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

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A 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.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug expenses have reached your initial coverage limit, including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B 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.

IPA – Independent Practice Association -- An independent group of physicians and other health-care providers under contract to provide services to members of managed care organizations.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy – 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 4 for more information about a medically accepted indication.

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

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan (where available), a PACE plan (where available), or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2012.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Your current Aetna Medicare Plan (PPO) does not include Medicare prescription drug coverage.

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

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the

federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

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

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B. Your current Aetna Medicare Plan (PPO) does not include Medicare prescription drug coverage

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

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 providers are independent contractors and not agents of Aetna.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are

called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether

they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care Physician (PCP) – Your primary care physician 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 Physicians.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. Covered services that need prior authorization are marked in the Benefits Chart included with this *Evidence of Coverage*. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Addendum A for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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 move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care

include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you, or if you are a member of our plan through an 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.

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

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration 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 Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

ADDENDUM A
AETNA MEDICARE[SM] PLAN (PPO)
2012 EVIDENCE OF COVERAGE

Important Contact Information for State Agencies

Alabama	
Quality Improvement Organization	Alabama Quality Assurance Foundation Two Perimeter Park South, Suite 200 West Birmingham, AL 35243 Phone: 205-970-1600 / 800-760-4550 www.aqaf.com
State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 770 Washington Avenue, RSA Plaza Suite 570 Montgomery, AL 36130 Phone: 334-242-5743 / 800-243-5463 http://www.alabamaageline.gov
State Medical Assistance Office	Medicaid Agency of Alabama P.O. Box 5624 Montgomery, AL 36103-5624 Phone: 334-242-5000 / 800-362-1504 www.medicaid.alabama.gov/
Alaska	
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation 4241 B Street, Suite 303 Anchorage, AK 99503 Phone: 406-443-4020 / 800-497-8232 www.mpqhf.org
State Health Insurance Assistance Program	Alaska State Health Insurance Assistance Program (SHIP) 550 West 8th Avenue Anchorage, AK 99501 Phone: 907-269-3680 / 800-478-6065 TTY: 907-269-3691 http://medicare.alaska.gov
State Medical Assistance Office	Alaska Department of Health and Social Services 350 Main Street, Room 404 P.O. Box 110601 Anchorage, AK 99811-0601 Phone: 907-465-3030 / 800-780-9972 TTY: 907-586-4265 www.hss.state.ak.us/dpa
Arizona	
Quality Improvement Organization	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 300 Phoenix, AZ 85016-4501 Phone: 602-264-6382 / 800-359-9909 www.hsag.com

State Health Insurance Assistance Program	Arizona State Health Insurance Assistance Program DES Division of Aging and Adult Services 1789 W. Jefferson St. (Site Code 950A) Phoenix, AZ 85007 Phone: 602-542-4446 / 800-432-4040 www.azdes.gov/aaa/programs/ship
State Medical Assistance Office	Health Care Cost Containment of Arizona 801 E. Jefferson Street, MD 4100 Phoenix, AZ 85034 Phone: 602-417-7000 / 800-654-8713 http://www.ahcccs.state.az.us
Arkansas	
Quality Improvement Organization	Arkansas Foundation for Medical Care 1020 West 4th Street, Suite 200 Little Rock, AR 72201 Phone: 501-212-8600 / 800-272-5528 www.afmc.org
State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIIP) Arkansas Insurance Department 1200 West Third Street Little Rock, AR 72201 Phone: 501-371-2782 / 800-224-6330 http://insurance.arkansas.gov/seniors/homepage.htm
State Medical Assistance Office	Department of Human Services of Arkansas Donaghey Plaza South P. O. Box 1437, Slot S401 Little Rock, AR 72203-1437 Phone: 501-682-8233 / 800-482-5431 http://www.medicaid.state.ar.us/
California	
Quality Improvement Organization	Health Services Advisory Group 700 North Brand Boulevard, Suite 300 Glendale, CA 91203 Phone: 866-800-8749 TTY: 800-881-5980 www.hsag.com
State Health Insurance Assistance Program	California Health Insurance Counseling & Advocacy Program (HICAP) Department of Aging 1300 National Drive Sacramento, CA 95834 Phone: 800-434-0222 www.aging.ca.gov/HICAP
State Medical Assistance Office	California Department of Health Services 1501 Capitol Avenue, MS 4604 Sacramento, CA 95814

	Phone: 916-636-1980 / 800-541-5555 TTY: 800-735-2929 www.medi-cal.ca.gov
Colorado	
Quality Improvement Organization	Colorado Foundation for Medical Care 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708 Phone: 303-695-3300 / 800-727-7086 www.cfmc.org
State Health Insurance Assistance Program	Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 303-894-7499 / 800-930-3745 TTY: 303-894-7880 www.dora.state.co.us/insurance/senior/senior.htm
State Medical Assistance Office	Department of Health Care Policy and Financing of Colorado 1570 Grant Street Denver, CO 80203-1818 Phone: 303-866-2993 / 800-221-3943 http://www.chcpf.state.co.us
State Pharmaceutical Assistance Program	Colorado Bridging the Gap - Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South DCEED-STD-A3 Denver, CO 80246-1530 Phone: 303-692-2700 TTY: 303-691-7719 http://www.cdphe.state.co.us/dc/HIVandSTD/ryanwhite/medicared.html
Connecticut	
Quality Improvement Organization	Qualidigm 1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067-3454 Phone: 860-632-2008 / 800-553-7590 www.qualidigm.org
State Health Insurance Assistance Program	CHOICES Department of Social Services, Aging Services Division 25 Sigourney Street, 10th Floor Hartford, CT 06106 Phone: 860-424-5274 / 866-218-6631 www.ct.gov/agingservices
State Medical Assistance Office	Department of Social Services of Connecticut 25 Sigourney Street Hartford, CT 06106-5033 Phone: 860-424-4908 / 800-842-1508 http://www.dss.state.ct.us

State Pharmaceutical Assistance Program	ConnPACE - Connecticut Department of Social Services P.O. Box 5011 Hartford, CT 06102 Phone: 860-269-2029 / 800-423-5026 http://www.connpace.com/
Delaware	
Quality Improvement Organization	Quality Insights of Delaware Baynard Bldg. Suite 100 3411 Silverside Road Wilmington, DE 19810-4812 Phone: 302-478-3600 / 866-475-9669 http://www.wvmi.org/corp/
State Health Insurance Assistance Program	ELDERinfo 841 Silver Lake Blvd Dover, DE 19904 Phone: 302-674-7364 / 800-336-9500 http://delawareinsurance.gov/departments/elder/eldindex.shtml
State Medical Assistance Office	Delaware Health and Social Services 1901 N. Du Pont Highway, Lewis Bldg. New Castle, DE 19720 Phone: 302-255-9500 / 800-372-2022 www.state.de.us/dhss
State Pharmaceutical Assistance Program	Chronic Renal Disease Program 11-13 Church Ave. Milford, DE 19963 Phone: 302-424-7180 / 800-464-4357 http://www.dhss.delaware.gov/dhss/dmma/crdprog.html
District of Columbia	
Quality Improvement Organization	Delmarva Foundation for Medical Care, Inc. 9240 Centreville Road Easton, MD 21601 Phone: 202-293-9650 / 800-937-3362 www.delmarvafoundation.org
State Health Insurance Assistance Program	Health Insurance Counseling Project (HICP) 441 4th Street, NW Suite 900 South Washington, DC 20001 Phone: 202-739-0668 TTY: 202-724-8925 http://dcoa.dc.gov/dcoa.site/default.asp
State Medical Assistance Office	DC Healthy Family 899 North Capitol Street, NE Washington, DC 20002 Phone: 202-724-5506 / 888-557-1116 www.doh.dc.gov
Florida	
Quality Improvement	Florida Medical Quality Assurance

Organization	5201 W. Kennedy Boulevard Suite 900 Tampa, FL 33609-1822 Phone: 813-354-9111 / 800-844-0795 www.fmqai.com
State Health Insurance Assistance Program	Serving Health Insurance Needs of Elders (SHINE) Department of Elder Affairs 4040 Esplanade Way Tallahassee, FL 32399-7000 Phone: 850-414-2000 / 800-963-5337 TTY: 800-414-2001 http://www.FloridaShine.org
State Medical Assistance Office	Agency for Health Care Administration of Florida 2727 Mahan Drive Tallahassee, FL 32308 Phone: 850-487-1111 / 866-762-2237 www.fdhc.state.fl.us/
Georgia	
Quality Improvement Organization	Georgia Medical Care Foundation 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346 Phone: 404-982-0411 / 800-982-0411 www.gmcf.org
State Health Insurance Assistance Program	GeorgiaCares 2 Peachtree Street, NW Atlanta, GA 30303 404-657-5258 / 800-669-8387 Phone: TTY: 404-657-1929 www.dhr.georgia.gov
State Medical Assistance Office	Georgia Department of Community Health 2 Peachtree Street, NW Atlanta, GA 30303 Phone: 404-651-9982 / 800-869-1150 www.dch.georgia.gov
Hawaii	
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation 1360 S. Beretania, Suite 501 Honolulu, HI 96814 Phone: 808-545-2550 / 800-524-6550 www.mpqhf.org
State Health Insurance Assistance Program	Sage PLUS Executive Office on Aging 250 South Hotel Street, Suite 406 Honolulu, HI 96813-2831 Phone: 808-586-0100 / 888-875-9229 http://hawaii.gov/health/eoa
State Medical Assistance	Department of Human Services of Hawaii

Office	1390 Miller Street, Room 209 Honolulu, HI 96813 Phone: 808-524-3370 / 800-316-8005 http://www.med-quest.us/
State Pharmaceutical Assistance Program	Hawaii State Pharmacy Assistance Program P.O. Box 700220 Kapolei, HI 96709 Phone: 808-692-7999 / 866-878-9769 http://www.med-quest.us/eligibility/EligPrograms_SPAP.html
Idaho	
Quality Improvement Organization	Qualis Health 720 Park Blvd., #120 Boise, ID 83712 Phone: 208-343-4617 / 800-488-1118 www.QualisHealthMedicare.org
State Health Insurance Assistance Program	Senior Health Insurance Benefits Advisors (SHIBA) 700 West State Street, P.O. Box 83720 Boise, ID 83720-0043 Phone: 208-334-4352 / 800-247-4422 www.doi.idaho.gov
State Medical Assistance Office	Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0036 Phone: 208-334-6700 / 800-926-2588 healthandwelfare.idaho.gov
State Pharmaceutical Assistance Program	Idaho AIDS Drug Assistance Program (IDAGAP) - Department of Health and Welfare P. O. Box 83720 Boise, ID 83720 Phone: 208-334-5943 / 800-926-2588 http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
Illinois	
Quality Improvement Organization	Illinois Foundation for Quality Health Care 711 Jorie Blvd., Suite #301 Oak Brook, IL 60523-4425 Phone: 630-928-5800 / 800-647-8089 www.ifmc-il.org
State Health Insurance Assistance Program	Senior Health Insurance Program (SHIP) 320 West Washington St. Springfield, IL 62767-0001 Phone: 217-785-9021 / 800-548-9034 TTY: 217-524-4872 http://insurance.illinois.gov/SHIP/
State Medical Assistance Office	Illinois Department of Healthcare and Family Services 201 South Grand Avenue East

	Springfield, IL 62763-0001 Phone: 217-782-1200 / 800-226-0768 TTY: 800-526-5812 http://www.hfs.illinois.gov/
State Pharmaceutical Assistance Program	Illinois Cares Rx Plus - Illinois Department on Aging P.O. Box 19003 Springfield, IL 62794 Phone: 800-624-2459 TTY: 800-206-1327 http://www.illinoiscaresrx.com/
Indiana	
Quality Improvement Organization	Health Care Excel, Inc. 2629 Waterfront Parkway East Drive, Suite 150 Indianapolis, IN 46214 Phone: 317-347-4500 / 800-288-1499 www.hce.org
State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 714 West 53rd Street Anderson, IN 46013 Phone: 765-608-2318 / 800-452-4800 TTY: 866-846-0139 www.medicare.in.gov
State Medical Assistance Office	Family and Social Services Administration of Indiana P.O. Box 7083 402 W. Washington Street Indianapolis, IN 46207-7083 Phone: 317-233-4454 / 800-403-0864 http://www.in.gov/fssa/
State Pharmaceutical Assistance Program	HoosierRx P.O. Box 6224 Indianapolis, IN 46206 Phone: 317-234-1381 / 866-267-4679 http://www.in.gov/fssa/elderly/hoosierrx/
Iowa	
Quality Improvement Organization	Iowa Foundation For Medical Care 1776 West Lakes Parkway West Des Moines, IA 50266 Phone: 515-223-2900 / 800-383-2856 www.ifmc.org
State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIIP) 330 Maple St. Des Moines, IA 50319-0065 Phone: 515-281-6867 / 800-351-4664 TTY: 800-735-2942 www.shiip.state.ia.us/
State Medical Assistance	Department of Human Services of Iowa

Office	P. O. Box 36510 Des Moines, IA 50315 Phone: 515-256-4606 / 800-338-8366 www.dhs.state.ia.us
Kansas	
Quality Improvement Organization	Kansas Foundation for Medical Care 2947 SW Wanamaker Drive Topeka, KS 66614-4193 Phone: 785-273-2552 / 800-432-0770 www.kfmc.org
State Health Insurance Assistance Program	Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Avenue Topeka, KS 66603 Phone: 316-337-7386 / 800-432-3535 www.agingkansas.org
State Medical Assistance Office	Department of Social and Rehabilitation Services of Kansas 915 Southwest Harrison Street Topeka, KS 66612 Phone: 785-296-3981 / 800-766-9012 TTY: 785-296-1491 http://www.srskansas.org/hcp/
Kentucky	
Quality Improvement Organization	Health Care Excel, Inc. 2629 Waterfront Parkway East Drive, Suite 150 Indianapolis, IN 46214 Phone: 317-347-4500 / 800-288-1499 www.hce.org
State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 275 E. Main St., 3E-E Frankfort, KY 40621 Phone: 502-564-6930 / 877-293-7447 TTY: 888-642-1137 http://www.chfs.ky.gov/dail/ship.htm
State Medical Assistance Office	Cabinet for Health Services of Kentucky 275 E. Main St. Frankfort, KY 40621 Phone: 502-564-4321 / 800-635-2570 www.chfs.ky.gov
Louisiana	
Quality Improvement Organization	Louisiana Health Care Review 8591 United Plaza Blvd., Suite 270 Baton Rouge, LA 70809 Phone: 225-926-6353 / 800-433-4958 www.lhcr.org
State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIIP) P.O. Box 94214

	Baton Rouge, LA 70804 Phone: 225-342-5301 / 800-259-5301 www.ldi.state.la.us
State Medical Assistance Office	Louisiana Department of Health and Hospital 628 N. 4th Street, P.O. Box 629 Baton Rouge, LA 70821-0629 Phone: 225-342-5774 / 888-342-6207 www.medicaid.dhh.louisiana.gov
Maine	
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Rd., Suite 302 Dover, NH 03820 Phone: 603-749-1641 / 800-772-0151 TTY: 877-486-2048 www.nhcqf.org
State Health Insurance Assistance Program	Maine State Health Insurance Assistance Program (SHIP) 11 State House Station, 32 Blossom Lane Augusta, ME 04333 Phone: 207-287-9200 / 800-262-2232 TTY: 800-606-0215 http://www.maine.gov/dhhs/oes/hiap/index.shtml
State Medical Assistance Office	Maine Department of Health and Human Services 11 State House Station Augusta, ME 04333-0011 Phone: 207-287-9202 / 800-977-6740 TTY: 800-606-0215 www.maine.gov/dhhs/bms
State Pharmaceutical Assistance Program	Maine Low Cost Drugs for the Elderly or Disabled Program - Office of MaineCare Services 442 Civic Center Drive Augusta, ME 04333 Phone: 888-600-2466 / 866-796-2463 TTY: 800-606-0215 http://www.maine.gov/dhhs/beas/resource/lc_drugs.htm
Maryland	
Quality Improvement Organization	Delmarva Foundation for Medical Care, Inc. 9240 Centreville Road Easton, MD 21601 Phone: 410-822-0697 / 800-999-3362 www.delmarvafoundation.org
State Health Insurance Assistance Program	Senior Health Insurance Assistance Program (SHIP) 301 West Preston Street, Suite 1007 Baltimore, MD 21201 Phone: 410-767-1100 / 800-243-3425

	TTY: 800-201-7165 http://www.mdoa.state.md.us
State Medical Assistance Office	Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201 Phone: 410-767-5800 / 800-492-5231 www.dhmh.state.md.us
State Pharmaceutical Assistance Program	Maryland Senior Prescription Drug Assistance Program - c/o Pool Administrators 628 Hebron Avenue, Suite 212 Glastonbury, CT 06033 Phone: 800-551-5995 TTY: 800-877-5156 http://marylandspdap.com
Massachusetts	
Quality Improvement Organization	MassPRO 245 Winter St. Waltham, MA 02451-1231 Phone: 781-890-0011 / 800-252-5533 www.masspro.org
State Health Insurance Assistance Program	Serving Health Information Needs of Elders (SHINE) One Ashburton Place, 5th Floor Boston, MA 02108 Phone: 617-727-7750 / 800-243-4636 www.800ageinfo.com
State Medical Assistance Office	Office of Health and Human Services of Massachusetts One Ashburton Place, 11th Floor Boston, MA 02108 Phone: 617-573-1600 / 800-841-2900 www.mass.gov/masshealth
State Pharmaceutical Assistance Program	Massachusetts Prescription Advantage P.O. Box 15153 Worcester, MA 01615 Phone: 800-243-4636 TTY: 877-610-0241 http://www.mass.gov/?pageID=eldersterminal&L=3&L0=Home&L1=Health+Care&L2=Prescription+Advantage&sid=Eelders&b=terminalcontent&f=pa_overview&csid=Eelders
Michigan	
Quality Improvement Organization	Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611 Phone: 248-465-7300 / 800-365-5899 www.mpro.org
State Health Insurance Assistance Program	MMAP, Inc. 6105 West St. Joseph, Suite 204

	Lansing, MI 48917-4850 Phone: 800-803-7174 mmapinc.org
State Medical Assistance Office	Michigan Department Community Health 201 Townsend Street Lansing, MI 48913 Phone: 517-373-3740 / 800-642-3195 TTY: 800-649-3777 www.michigan.gov/mdch
Minnesota	
Quality Improvement Organization	Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525 Phone: 952-854-3306 / 877-787-2847 www.stratishealth.org
State Health Insurance Assistance Program	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line P.O. Box 64976 St. Paul, MN 55164-0976 Phone: 800-333-2433 http://www.mnaging.org/
State Medical Assistance Office	Department of Human Services of Minnesota - MinnesotaCare P.O. Box 64989 St Paul, MN 55164-0989 Phone: 651-431-2670 / 800-657-3739 TTY: 800-627-3529 http://www.dhs.state.mn.us/
Mississippi	
Quality Improvement Organization	Information and Quality Healthcare 385B Highland Colony Parkway, Suite 504 Ridgeland, MS 39157 Phone: 601-957-1575 / 800-844-0600 www.iqh.org
State Health Insurance Assistance Program	MS State Health Insurance Assistance Program (SHIP) 750 North State Street Jackson, MS 39202 Phone: 601-359-4929 / 800-948-3090 http://www.mdhs.state.ms.us/aas_ship.html
State Medical Assistance Office	Office of the Governor of Mississippi 550 High Street, Suite 1000 Jackson, MS 39201-1399 Phone: 601-359-6050 / 800-421-2408 medicaid.ms.gov/
Missouri	
Quality Improvement Organization	Primaris 200 N. Keene Street, Ste. 101

	Columbia, MO 65201 Phone: 573-817-8300 / 800-735-6776 http://www.primaris.org/
State Health Insurance Assistance Program	CLAIM 200 N. Keene St. Columbia, MO 65201 Phone: 573-817-8320 / 800-390-3330 www.missouriclaim.org
State Medical Assistance Office	Department of Social Services of Missouri - MO HealthNet Division 615 Howerton Court, P.O. Box 6500 Jefferson City, MO 65102-6500 Phone: 573-751-3425 / 800-392-2161 TTY: 800-735-2966 www.dss.mo.gov/mhd/
State Pharmaceutical Assistance Program	Missouri Rx Plan P.O. Box 6500 Jefferson City, MO 65102 Phone: 573-751-3425 / 800-375-1406 TTY: 800-735-2966 http://morx.mo.gov/
Montana	
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 Phone: 406-443-4020 / 800-362-5880 www.mpqhf.org
State Health Insurance Assistance Program	Montana State Health Insurance Assistance Program (SHIP) 2030 - 11th Ave Helena, MT 59604-4210 Phone: 406-444-7870 / 800-551-3191 http://www.dphhs.mt.gov/sltc/services/aging/ship.shtml
State Medical Assistance Office	Montana Department of Public Health & Human Services-Division of Child and Adult Health Resources 2030 11th Avenue Helena, MT 59601 Phone: 800-362-8312 http://www.dphhs.mt.gov
State Pharmaceutical Assistance Program	Bridging the Gap P.O. Box 202951, Cogswell Building C-211 Helena, MT 59620 Phone: 406-444-4744 http://www.dphhs.mt.gov/PHSD/STD-HIV/std-hiv-consorti.shtml
Nebraska	
Quality Improvement	Cimro of Nebraska

Organization	1230 O Street, Suite 120 Lincoln, NE 68508 Phone: 402-476-1399 / 800-458-4262 www.cimronebraska.org
State Health Insurance Assistance Program	Nebraska Senior Health Insurance Information Program (SHIIP) 941 O Street Suite 400 P.O. Box 82089 Lincoln, NE 68501 Phone: 402-471-2201 / 800-234-7119 TTY: 800-833-7352 www.doi.ne.gov/shiip
State Medical Assistance Office	Nebraska Department of Health and Human Services System 301 Centennial Mall South Lincoln, NE 68509 Phone: 402-471-3121 / 800-430-3244 www.hhs.state.ne.us
Nevada	
Quality Improvement Organization	HealthInsight 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118 Phone: 702-385-9933 / 800-748-6773 www.healthinsight.org
State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 3416 Goni Road, Suite D-132 Carson City, NV 89706 Phone: 702-486-3478 / 800-307-4444 www.nvaging.net
State Medical Assistance Office	Nevada Department of Human Resources, Aging Division 1100 E. William Street, Suite 101 Carson City, NV 89701 Phone: 775-684-3600 / 800-992-0900 TTY: 775-684-0760 http://dhcfp.state.nv.us/
State Pharmaceutical Assistance Program	Nevada Disability Rx-Department of Health and Human Services 3416 Goni Road, Suite D-113 Carson City, NV 89706 Phone: 775-687-4210 / 866-303-6323 http://dhhs.nv.gov/DisabilityRx.htm
New Hampshire	
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Rd., Suite 302 Dover, NH 03820 Phone: 603-749-1641 / 800-772-0151 TTY: 877-486-2048

	www.nhcqf.org
State Health Insurance Assistance Program	NH SHIP - ServiceLink Resource Center 67 Water St., Suite 105 Laconia, NH 03246 Phone: 603-528-6945 / 866-634-9412 www.servicelink.org
State Medical Assistance Office	New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301 Phone: 603-271-4344 / 800-852-3345 TTY: 800-735-2964 http://www.dhhs.state.nh.us
New Jersey	
Quality Improvement Organization	Health Care Quality Strategies 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816 Phone: 732-238-5570 / 800-624-4557 TTY: 877-486-8048 www.hqsi.org
State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) P. O. Box 360 Trenton, NJ 08625-0360 Phone: 877-222-3737 / 800-792-8820 www.state.nj.us/health/senior/ship.shtml
State Medical Assistance Office	Department of Human Services of New Jersey P.O. Box 712 Trenton, NJ 08625-0712 Phone: 800-356-1561 www.state.nj.us/humanservices/dmahs
State Pharmaceutical Assistance Program	New Jersey Division of Medical Assistance and Health Services Quakerbridge Plaza, P.O. Box 712 Trenton, NJ 08625 Phone: 800-356-1561 http://www.state.nj.us/humanservices/dmahs/index.html
New Mexico	
Quality Improvement Organization	New Mexico Medical Review Association 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109 Phone: 505-998-9898 / 800-663-6351 www.nmmra.org
State Health Insurance Assistance Program	Benefits Counseling Program 2550 Cerrillos Road Santa Fe, NM 87505 Phone: 505-476-4846 / 800-432-2080 TTY: 800-659-8331

	www.nmaging.state.nm.us
State Medical Assistance Office	Department of Human Services of New Mexico P.O. Box 2348 Santa Fe, NM 87504-2348 Phone: 505-827-3100 / 888-997-2583 http://www.state.nm.us/hsd/mad/Index.html
New York	
Quality Improvement Organization	Island Peer Review Organization - IPRO 1979 Marcus Avenue Lake Success, NY 11042-1002 Phone: 516-326-7767 / 800-331-7767 TTY: 516-326-6182 www.ipro.org
State Health Insurance Assistance Program	Health Insurance Information Counseling and Assistance Program (HIICAP) 162 Washington Ave. Albany, NY 12210 Phone: 800-342-9871 / 800-701-0501 TTY: 877-486-2048 www.aging.ny.gov/
State Medical Assistance Office	New York State Department of Health P.O. Box 2798 New York, NY 10117-2273 Phone: 518-486-9057 / 800-541-2831 http://www.health.state.ny.us/
State Pharmaceutical Assistance Program	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) P.O. Box 15018 Albany, NY 12212 Phone: 800-332-3742 http://www.health.state.ny.us/nysdoh/epic/faq.htm
North Carolina	
Quality Improvement Organization	Medical Review of North Carolina, Inc. 100 Regency Forest Drive, Suite 200 Cary, NC 27518-8598 Phone: 919-380-9860 / 800-682-2650 www.thecarolinascenter.org/
State Health Insurance Assistance Program	Seniors' Health Insurance Information Program (SHIIP) 11 South Boylan Avenue Raleigh, NC 27603 Phone: 919-807-6900 / 800-443-9354 TTY: 919-715-0319 http://www.ncdoi.com/SHIIP/shiip_contact.asp
State Medical Assistance Office	North Carolina Department of Health and Human Services 2001 Mail Service Center

	Raleigh, NC 27699-2001 Phone: 919-855-4400 / 800-662-7030 TTY: 919-733-4851 www.dhhs.state.nc.us/dma/mqb.html
State Pharmaceutical Assistance Program	North Carolina HIV SPAP 1902 Mail Service Center Raleigh, NC 27699 Phone: 919-733-7301 / 877-466-2232 http://www.epi.state.nc.us/epi/hiv/adap.html
North Dakota	
Quality Improvement Organization	North Dakota Health Care Review, Inc. 800 31st Avenue SW Minot, ND 58701 Phone: 701-852-4231 / 888-472-2902 www.ndhcri.org
State Health Insurance Assistance Program	Senior Health Insurance Counseling (SHIC) 600 E. Boulevard Ave. Bismarck, ND 58505-0320 Phone: 701-328-2440 / 800-247-0560 TTY: 800-366-6888 http://www.state.nd.us/ndins/
State Medical Assistance Office	Dept of Human Services of North Dakota - Medical Services 600 E Boulevard Ave, Dept 325 Bismarck, ND 58505-0250 Phone: 701-328-2321 / 800-755-2604 www.nd.gov/dhs/
Ohio	
Quality Improvement Organization	Ohio KePRO, Inc. Rock Run Center, Suite 100 5700 Lombardo Center Dr. Seven Hills, OH 44131 Phone: 216-447-9604 / 800-589-7337 www.ohiokepro.com
State Health Insurance Assistance Program	Ohio Senior Health Insurance Information Program (OSHIIP) 50 W. Town Street, Third Floor - Suite 300 Columbus, OH 43215 Phone: 614-644-3458 / 800-686-1578 TTY: 614-644-3745 www.insurance.ohio.gov
State Medical Assistance Office	Department of Job and Family Services of Ohio - Ohio Health Plans 50 West Town Street Columbus, OH 43215 Phone: 614-644-0140 / 800-324-8680 http://jfs.ohio.gov/ohp
Oklahoma	

Quality Improvement Organization	Oklahoma Foundation for Medical Quality, Inc. 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600 Phone: 405-840-1343 / 800-522-3414 www.ofmq.com
State Health Insurance Assistance Program	Senior Health Insurance Counseling Program (SHIP) 4157 S. Harvard, Suite. 121 Tulsa, OK 74135 Phone: 405-521-6628 / 800-763-2828 www.oid.state.ok.us
State Medical Assistance Office	Health Care Authority of Oklahoma 2401 N.W. 23rd St., Suite 1A Oklahoma City, OK 73107 Phone: 405-522-7171 / 800-522-0310 www.okhca.org
Oregon	
Quality Improvement Organization	Acumentra Health 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201 Phone: 503-279-0100 / 800-344-4354 www.acumentra.org
State Health Insurance Assistance Program	Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter Street NE, Suite 330 P.O. Box 14480 Salem, OR 97309-0405 Phone: 503-947-7979 / 800-722-4134 TTY: 800-735-2900 http://oregonshiba.org/
State Medical Assistance Office	Oregon Department of Human Services 500 Summer St. NE Salem, OR 97301 Phone: 503-945-5772 / 800-527-5772 TTY: 503-945-6214 www.oregon.gov/dhs/index.shtml
Pennsylvania	
Quality Improvement Organization	Quality Insights of Pennsylvania 2601 Market Place Street, Suite 320 Harrisburg, PA 17110 Phone: 717-671-5425 / 877-346-6180 www.qipa.org
State Health Insurance Assistance Program	APPRISE 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 Phone: 717-783-1550 / 800-783-7067 www.aging.state.pa.us
State Medical Assistance	Department of Public Welfare of Pennsylvania

Office	P.O. Box 2675 Harrisburg, PA 17105-2675 Phone: 800-692-7462 www.dpw.state.pa.us
State Pharmaceutical Assistance Program	Department of Public Welfare Special Pharmaceutical Benefits Program P.O. Box 8021 Harrisburg, PA 17105 Phone: 800-922-9384 http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/aidswaiverprogram/specialpharmaceuticalbenefitsprogram/index.htm
Rhode Island	
Quality Improvement Organization	Rhode Island Quality Partners, Inc. 235 Promenade Street, Suite 500, Box 18 Providence, RI 02908 Phone: 401-528-3200 / 800-662-5028 www.riqualitypartners.org
State Health Insurance Assistance Program	Senior Health Insurance Program (SHIP) 74 West Road, Hazard Bldg. Cranston, RI 02920 Phone: 401-462-4444 TTY: 401-462-0740 http://adrc.ohhs.ri.gov
State Medical Assistance Office	Department of Human Services of Rhode Island 206 Elmwood Avenue Providence, RI 02907 Phone: 401-462-5300 www.dhs.ri.gov
State Pharmaceutical Assistance Program	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) - Attention RIPAE Rhode Island Department of Elderly Affairs 74 West Road, Hazard Building, Second Floor Cranston, RI 02920 Phone: 401-462-3000 TTY: 401-462-0740 http://www.dea.state.ri.us/programs/prescription_assist.php
South Carolina	
Quality Improvement Organization	Carolina Center for Medical Excellence 246 Stoneridge Drive, Suite 200 Columbia, SC 29210 Phone: 803-251-2215 / 800-922-3089 www.thecarolinascenter.org
State Health Insurance Assistance Program	(I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais Street, Suite 350

	Columbia, SC 29201 Phone: 803-734-9900 / 800-868-9095 www.aging.sc.gov
State Medical Assistance Office	South Carolina Department of Health and Human Services P. O. Box 8206 Columbia, SC 29202-8206 Phone: 803-898-2500 / 888-549-0820 http://www.dhhs.state.sc.us
South Dakota	
Quality Improvement Organization	South Dakota Foundation for Medical Care, Inc. 2600 West 49th Street, Suite 300 Sioux Falls, SD 57105 Phone: 605-336-3505 / 800-658-2285 www.sdfmc.org
State Health Insurance Assistance Program	Senior Health Information & Insurance Education (SHIINE) 811 E 10th St Sioux Falls, SD 57103 Phone: 605-333-3314 / 800-536-8197 www.shiine.net
State Medical Assistance Office	Department of Social Services of South Dakota 700 Governors Drive Pierre, SD 57501 Phone: 605-773-3495 / 800-597-1603 www.state.sd.us/social/medical
Tennessee	
Quality Improvement Organization	Q Source 3175 Lenox Park Blvd., Suite 309 Memphis, TN 38115 Phone: 901-682-0381 / 800-528-2655 www.qsource.org
State Health Insurance Assistance Program	TN SHIP 500 Deaderick Street, Suite 825 Nashville, TN 37243-0860 Phone: 615-741-2056 / 877-801-0044 TTY: 615-532-3893 www.state.tn.us/comaging/
State Medical Assistance Office	Bureau of TennCare 310 Great Circle Rd. Nashville, TN 37243 Phone: 800-342-3145 TTY: 877-779-3103 http://state.tn.us/tenncare
Texas	
Quality Improvement Organization	TMF Health Quality Institute Bridgepoint I, Suite 300 5918 West Courtyard Drive

	Austin, TX 78730-5036 Phone: 512-329-6610 / 800-725-9216 TTY: 877-486-2048 www.tmf.org
State Health Insurance Assistance Program	Health Information Counseling and Advocacy Program (HICAP) P.O. Box 149030 Austin, TX 78714-9030 Phone: 512-438-3011 / 800-252-9240 www.dads.state.tx.us
State Medical Assistance Office	Health and Human Services Commission of Texas 4900 N. Lamar Blvd. Austin, TX 78751-2316 Phone: 512-424-6500 / 800-252-8263 http://www.hhsc.state.tx.us
State Pharmaceutical Assistance Program	Texas HIV State Pharmacy Assistance Program (SPAP) P.O. Box 149347 ATTN: MSJA-MC 1873 Austin, TX 78714 Phone: 800-255-1090 http://www.dshs.state.tx.us/hivstd/meds/spap.shtm
Utah	
Quality Improvement Organization	HealthInsight 348 E. 4500 S., Suite 300 Salt Lake City, UT 84107 Phone: 801-892-0155 / 800-748-6773 www.healthinsight.org
State Health Insurance Assistance Program	Senior Health Insurance Information Program (SHIP) 195 North 1950 West Salt Lake City, UT 84116 Phone: 801-538-3910 / 877-424-4640 http://www.hsdaas.utah.gov/insurance_programs.htm
State Medical Assistance Office	Utah Department of Health P.O. Box 143106 Salt Lake City, UT 84114-3106 Phone: 801-538-6155 / 800-662-9651 http://health.utah.gov/medicaid/
Vermont	
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Rd., Suite 302 Dover, NH 03820 Phone: 603-749-1641 / 800-772-0151 TTY: 877-486-2048 www.nhcqf.org
State Health Insurance Assistance Program	State Health Insurance Assistance Program (SHIP) 481 Summer Street, Suite 101

	St. Johnsbury, VT 05819 Phone: 802-748-5182 / 800-642-5119 http://www.medicarehelpvt.net/
State Medical Assistance Office	Agency of Human Services of Vermont 103 South Main Street Waterbury, VT 05676-1500 Phone: 802-879-5900 / 800-479-6151 TTY: 800-479-6151 http://humanservices.vermont.gov/
State Pharmaceutical Assistance Program	VPharm 312 Hurricane Lane, Suite 201 Williston, VT 05495 Phone: 800-250-8427 TTY: 888-834-7898 http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance
Virginia	
Quality Improvement Organization	Virginia Health Quality Center 9830 Mayland Drive, Suite J Richmond, VA 23233 Phone: 804-289-5320 / 866-263-8402 TTY: 877-486-2048 www.vhqc.org
State Health Insurance Assistance Program	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue, Suite 100 Richmond, VA 23229 Phone: 804-662-9333 / 800-552-3402 TTY: 800-552-3402 www.vda.virginia.gov
State Medical Assistance Office	Department of Medical Assistance Services 600 East Broad Street Richmond, VA 23219 Phone: 804-786-7933 TTY: 800-343-0634 http://dmasva.dmas.virginia.gov/default.aspx
State Pharmaceutical Assistance Program	Virginia HIV SPAP P.O. Box 5930 Midlothin, VA 23112 Phone: 800-366-7741 http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/spap.htm
Washington	
Quality Improvement Organization	Qualis Health P.O. Box 33400 Seattle, WA 98133-0400

	Phone: 206-364-9700 / 800-949-7536 TTY: 877-486-2048 www.QualisHealthMedicare.org
State Health Insurance Assistance Program	Statewide Health Insurance Benefits Advisors (SHIBA) Helpline P.O. Box 40256 Olympia, WA 98504-0256 Phone: 800-562-6900 TTY: 360-586-0241 http://www.insurance.wa.gov
State Medical Assistance Office	Department of Social and Health Services of Washington Office Building Two 14th and Jefferson Street Olympia, WA 98504 Phone: 800-562-3022 www.adsa.dshs.wa.gov
State Pharmaceutical Assistance Program	Washington State Health Insurance Pharmacy Assistance Program P.O. Box 1090 Great Bend, KS 67530 Phone: 800-877-5187 https://www.wship.org/Default.asp
West Virginia	
Quality Improvement Organization	West Virginia Medical Institute, Inc. 3001 Chesterfield Avenue Charleston, WV 25304 Phone: 304-346-9864 / 800-642-8686 www.wvmi.org
State Health Insurance Assistance Program	West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East Charleston, WV 25305 Phone: 304-558-3317 / 877-987-4463 www.wvship.org
State Medical Assistance Office	West Virginia Department of Health & Human Resources 350 Capitol Street, Room 251 Charleston, WV 25301 Phone: 304-558-1700 / 800-642-8589 http://www.dhhr.wv.gov/bms/
Wisconsin	
Quality Improvement Organization	MetaStar, Inc. 2909 Landmark Place Madison, WI 53713 Phone: 608-274-1940 / 800-362-2320 www.metastar.com
State Health Insurance	Wisconsin SHIP (SHIP)

Assistance Program	1 West Wilson Street Madison, WI 53703 Phone: 608-267-3201 / 800-242-1060 TTY: 888-701-1251 www.dhfs.state.wi.us/aging/SHIP.htm
State Medical Assistance Office	Wisconsin Department of Health 1 West Wilson Street Madison, WI 53703 Phone: 608-266-1865 / 800-362-3002 TTY: 888-701-1251 http://www.dhfs.state.wi.us/medicaid/index.htm
State Pharmaceutical Assistance Program	Wisconsin Chronic Renal Disease P. O. Box 6410 Madison, WI 53716 Phone: 800-362-3002 / 800-947-9627 https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/wcdp/index.htm.spage
Wyoming	
Quality Improvement Organization	Mountain-Pacific Quality Health Foundation P.O. Box 2242 Glenrock, WY 82637 Phone: 307-436-8733 / 877-810-6248 www.mpqhf.org
State Health Insurance Assistance Program	Wyoming State Health Insurance Information Program (WSHIIP) P.O. Box BD Riverton, WY 82501 Phone: 307-856-6880 / 800-856-4398 http://www.wyomingseniors.com/
State Medical Assistance Office	Wyoming Department of Health 401 Hathaway Building Cheyenne, WY 82002 Phone: 307-777-7656 / 866-571-0944 health.wyo.gov

Notes

Aetna Medicare Member Services

CALL	Please call the telephone number printed on the back of your member ID card. Calls to this number are free. Hours of Operation: 8 a.m. to 8 p.m., 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-888-760-4748 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m. to 8 p.m., 7 days a week.
WRITE	Aetna Medicare P.O. Box 14088 Lexington, KY 40512-4088
WEBSITE	www.aetnaretireeplans.com

State Health Insurance Assistance Program

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 in this *Evidence of Coverage*.