

Aetna  
Certificate of Coverage

City of Seattle – Retirees  
Medicare Open Plan

January 1, 2010

**AETNA LIFE INSURANCE COMPANY**  
**2010 AETNA MEDICARE OPEN<sup>SM</sup> PLAN (PFFS)**  
**GROUP AGREEMENT COVER SHEET**

**Contract Holder:** The City Of Seattle

**Contract Holder Number:** 395280  
001, 002, 003, 004, 005, 006, 007, 008, 009, 010,  
011, 012, 013, 014, 015, 016, 017, 018, 019, 020,  
022, 023, 024, 025, 026, 027, 028, 029, 030, 031,  
032, 033, 034, 035, 036, 037, 038, 039, 040, 041,  
042, 043, 044, 045, 046, 047, 048, 049, 050, 051,  
052, 053, 054, 055, 056, 057, 058, 059, 060, 061,  
062, 063, 064, 065, 066, 067, 068, 069, 070, 071,  
072, 073, 074, 075, 076, 077, 078, 079, 080, 081,  
082, 083, 084

AK30, AL30, AR31, AZ01, AZ30, CA01, CA02,  
CA04, CA05, CA30, CA31, CO01, CO31, FL02,  
FL03, FL04, FL31, GA01, GA04, GN03, HI30,  
IA30, IA31, ID30, IL02, IL03, IL31, IN04, IN32,  
KS30, KS31, LA01, LA31, ME01, MD01, MD02,  
MI01, MI31, MN30, MO33, MS30, MT30, NB30,  
NC29, NC30, ND30, NE01, NH01, NJ01, NM30,  
NV01, NV02, NV30, OH01, OH02, OH30, OH31,  
OK01, OK02, OK30, OR30, PA01, PA04, PA09,  
SC01, SD30, TN01, TN31, TX01, TX02, TX03,  
TX04, TX05, TX34, UT30, VA01, VA02, VA31,  
WA01, WA30, WI30, WY30

**PFFS Plan:** MED 20 OPEN PFFS Benefits Package  
with Medicare Prescription Drug benefits

**Effective Date:** 12:01 a.m. on January 1, 2010

**Term of Group Agreement:** The **Initial Term** shall be: From January 1, 2010  
through December 31, 2010  
Thereafter, **Subsequent Terms** shall be: From  
January 1st through December 31st

**Premium Due Dates:** The **Group Agreement Effective Date** and the 1st  
day of each succeeding calendar month.

**PFFS Plan Premium Rates:**

Please refer to the rate/financial exhibit, financial caveats document and/or final renewal communication (and any amendments made thereto) issued by **Aetna** in connection with this **Group Agreement** (“Rate Documents”) for applicable rates.

**Term of Rates:**

From January 1, 2010 to December 31, 2010. These rates are subject to adjustments based on final regulatory determinations.

**Governing Law:**

Federal law and applicable laws of the state of Washington.

**Notice Address for Aetna:**

1425 Union Meeting Road  
Post Office Box 1445  
Blue Bell, PA 19422

and for **Contract Holder** at:

The City Of Seattle  
Ms. Renee Freiboth  
Benefit Admin  
The City Of Seattle  
700 5th Avenue  
Suite 5500  
Seattle WA 98104

**NOTICE:** Any dispute arising from or related to this **Group Agreement** will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process, except as applicable law, as defined in the Applicable Law section of this **Group Agreement**, provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by this **Group Agreement** were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. This agreement to arbitrate also limits certain remedies and precludes the award of punitive damages. See Sections “Binding Arbitration” and “Limitations on Remedies” of the **EOC** for further information.

The **Contract Holder** and any **Group(s)** eligible through **Contract Holder**, if different from **Contract Holder**, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. **This means that the Contract Holder Group and other interested parties, will not be able to try their case in court. The Contract Holder further understands and accepts that Contract Holder and Group are giving up certain remedies and cannot recover punitive damages.**

The signature below is evidence of **Aetna’s** and **Contract Holder’s** acceptance of the **Contract Holder’s** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of **Aetna** and **Contract Holder**.

**AETNA LIFE INSURANCE COMPANY**

By:   
Gregory S. Martino  
Vice President

**AETNA LIFE INSURANCE COMPANY  
(WASHINGTON)**

**AETNA MEDICARE OPEN<sup>SM</sup> PLAN (PFFS)  
GROUP AGREEMENT**

This **Group Agreement** is entered into by and between Aetna Life Insurance Company and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium**, this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

**SECTION 1. DEFINITIONS**

- 1.1 “**Aetna Medicare PFFS plan**” or “**Plan**” means the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)**, including Medicare Prescription Drug benefits, offered by **Aetna** to **Contract Holder** under this **Group Agreement**.
- 1.2 The terms “**Aetna**”, “**Us**”, “**We**” or “**Our**” mean Aetna Life Insurance Company, an affiliate or a third party vendor.
- 1.3 “**CMS**” means the Centers for Medicare and Medicaid Services.
- 1.4 The terms “**Contract Holder**”, “**Effective Date**”, “**Initial Term**”, “**Premium Due Date**” and “**Subsequent Terms**” will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:
- “**Effective Date**” means the date health coverage commences for the **Contract Holder**.
  - “**Initial Term**” is the period following the **Effective Date** as indicated on the Cover Sheet.
  - “**Premium Due Date(s)**” is the **Effective Date** and each monthly anniversary of the **Effective Date**,

- “**Subsequent Term(s)**” means the periods following the **Initial Term** as indicated on the Cover Sheet.
- 1.5 “**Covered Benefits**” is a general term we use to mean all of the health care services and supplies, including Medicare prescription drug benefits, that are covered by **Our Plan**, subject to all of the terms and conditions of the **EOC** and this **Group Agreement**.
  - 1.6 “**EOC**” means the Evidence of Coverage, which is a document outlining coverage for **Members** that is issued pursuant to this **Group Agreement**, and includes the Schedule of Copayments, and any riders, amendments, or endorsements.
  - 1.7 “**Grace Period**” is defined in the Premiums and Fees section of this **Group Agreement**.
  - 1.8 “**Group Agreement**” means the **Contract Holder’s** Group Application, this document, the attached Cover Sheet; the **EOC** and Schedule of Copayments issued hereunder; the Rate Documents issued by **Us** in connection with this **Group Agreement**; the Plan Design and Benefit Summary; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into or incorporated by reference into and made a part of this **Group Agreement**.
  - 1.9 “**Member**” is a Medicare beneficiary who: (1) has enrolled in **Our Plan** and whose enrollment in the **Plan** has been confirmed by CMS, and (2) is eligible to receive coverage under the **Plan**, subject to the terms and conditions of the **EOC** and this **Group Agreement**.
  - 1.10 “**Member Premium(s)**” is defined in the Premium and Fees section.
  - 1.11 “**Party, Parties**” means **Aetna** and **Contract Holder**.
  - 1.12 “**Premium(s)**” is defined in the **Premiums and Fees** section below.
  - 1.13 “**Provider**” is the general term used for doctors, hospitals, and other health care professionals or facilities.
  - 1.14 “**Renewal Date**” means the first day following the end of the **Initial Term** or any **Subsequent Term**.
  - 1.15 “**Term**” means the **Initial Term** or any **Subsequent Term** set forth in the Cover Sheet to this **Group Agreement**.
  - 1.16 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **EOC**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **EOC**, the terms of this **Group Agreement** shall prevail.

## **SECTION 2. COVERAGE AND ACCESS TO PROVIDERS**

- 2.1 **Covered Benefits.** We will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.
- 2.2 **Policies and Procedures.** We have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **EOC** in order to promote orderly and efficient administration.
- 2.3 **Access to Providers.** **Members** can receive **Covered Benefits** from any licensed **Provider** that is eligible to receive payment under **Original Medicare**, agrees to treat the **Member** and accepts the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** Terms and Conditions of Participation. **Contract Holder** acknowledges that the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** does not offer a contracted network of **Providers** and **Providers** are not required to treat **Members**, except in emergency and urgent situations.

## **SECTION 3. PREMIUMS AND FEES**

- 3.1 **Premiums.** **Members** shall pay **Us** on or before each **Premium Due Date** a monthly advance **Member Premium** (the "**Member Premium**") determined in accordance with the **Member Premium** rates and the manner of calculating **Member Premiums** specified by **Aetna**. **Member Premium** rates and the manner of calculating **Member Premiums** may be adjusted in accordance with the **Changes in Premium and Membership Adjustments** sections below. **Member Premiums** are subject to adjustment, if any, for partial month participation as specified in the **Membership Adjustments** section below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Member Premiums** without waiving **Our** right to collect the entire amount due.

This **Group Agreement** is subject to the annual renewal of the **Aetna's** Medicare Advantage Contract with the federal government. **Covered Benefits** and/or **Premiums** are also subject to change at the beginning of a **Term** of this **Group Agreement**. Increases in **Member Premiums** and/or decreases in **Covered Benefits** are only permitted at the beginning of a **Term** of this **Group Agreement**. Should **CMS** cancel **Aetna's** contract as a Medicare Advantage contractor or should **Aetna** decide not to continue as a Medicare Advantage contractor, **Members** shall be given notice of such termination in accordance with the **Aetna Medicare Advantage EOC** and any applicable **CMS** requirements.

- 3.2 **Fees.** In addition to the **Member Premium**, **We** may charge the following fees:

- An installation fee may be charged to **Contract Holder** upon initial installation of coverage or any significant change in installation (e.g. a significant change in the number of **Members** or a change in the method of reporting **Member** eligibility to **Us**). A fee may also be charged upon initial installation for any custom plan set-ups.
- A reinstatement fee as set forth in the Effect of Termination section.

3.3 **Past Due Premiums and Fees.** If all **Member Premiums** are not received from a **Member** within ninety (90) days following the **Premium Due Date** (the “**Member Grace Period**”), the **Member’s** failure to make such payments may result in termination of the **Member’s** coverage under this **Group Agreement** (in accordance with the termination provisions in the **EOC**), and may result in termination of the **Group Agreement** pursuant to the Termination by **Us** section hereof.

If the **Group Agreement** terminates for any reason, **Member** will continue to be held liable for all **Member Premiums** due and unpaid before the termination, including, but not limited to, **Member Premium** payments for any period of time the **Group Agreement** is in force during the **Member Grace Period**. **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Member Grace Period**. We may recover from **Contract Holder**, **Our** costs of collecting any unpaid **Member Premiums** or fees, including reasonable attorney’s fees and cost of suit.

3.4 **Changes in Premium.** We may adjust the **Member Premium** rates and/or the manner of calculating **Member Premiums** to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing **Covered Benefits** to **Members**. Any changes to **Member Premiums** shall be made in accordance with applicable **CMS** requirements.

3.5 **Membership Adjustments.** Retroactive additions of **Members** will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Member Premiums**.

3.6 **Uniform Premiums and Low Income Subsidy.** **Contract Holder** shall comply with the following conditions with respect to any subsidization of that portion of **Premiums** paid by **Contract Holder** for the Medicare Prescription Drug benefit (“**MA-PD Premium**”) and any required **MA-PD Premium** contribution by the **Member**:

- **Contract Holder** may subsidize different amounts of **MA-PD Premium** for different classes of **Members** and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Classes of **Members** and their dependents cannot be based on eligibility for the **Low Income Subsidy** (“**LIS**”) provided by **CMS** for certain individuals.

- MA-PD Premium contribution levels cannot vary for **Members** within a given class.
- Direct subsidy payments from **CMS** to **Aetna** must be passed through to reduce the amount of any required MA-PD Premium payment by the **Member** (“Member Contribution”) so the **Member** in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from **CMS**, and b) one hundred percent (100%) for any supplemental coverage selected by the **Member**.

**Contract Holder** shall comply with the following conditions with respect to any LIS payment received from **CMS** for any LIS-eligible **Member**:

- Any monthly LIS payment received from **CMS** for an LIS-eligible **Member** shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the **Contract Holder’s** MA-PD Premium contribution.
- If the LIS payment for any LIS-eligible **Member** is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), **Contract Holder** shall communicate with the LIS-eligible **Member** about the cost of remaining enrolled in **Contract Holder’s** plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.

#### **SECTION 4. ENROLLMENT**

4.1 **Open Enrollment.** As described in the **EOC**, **Contract Holder** will offer enrollment in the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)**:

- at least once during every twelve month period during the Open Enrollment Period; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the Open Enrollment Period or 31 days of becoming eligible, may be enrolled during any subsequent Open Enrollment Period. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the Open Enrollment Period consistent with the Open Enrollment Period applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law or as otherwise required by **CMS**. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **EOC**, other enrollment periods may apply.

- 4.2 **Waiting Period.** **Contract Holder** may impose a waiting period before individuals are eligible for coverage under this **Group Agreement**.
- 4.3 **Eligibility.** The number of eligible individuals and eligible dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the Schedule of Copayments, or any other eligibility requirements as described in the **EOC** and on the Schedule of Copayments, for the purposes of enrolling **Contract Holder's** eligible individuals and eligible dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

## **SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER**

In addition to other obligations set forth in this **Group Agreement**, **Contract Holder** agrees to:

- 5.1 **(A) Records.** Furnish to **Us**, on a monthly basis (or as otherwise required), on **Our** form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

**Contract Holder** represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to **Us** by **Contract Holder** (in electronic or hard copy format), **Contract Holder** agrees to:

- Obtain from all **Subscribers** a “Disclosure of Healthcare Information” authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

**We** will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Member's** employment/eligibility to be enrolled in the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** ceases for the purpose of termination of coverage under this **Group Agreement**.

**(B) Maintenance of Information and Records.** **Contract Holder** agrees to maintain **Information and Records** (as those terms are defined in the Access to Information and Records section below) in a current, detailed, organized and comprehensive manner and

in accordance with applicable laws, rules and regulations, and to maintain such Information and Records for the longer of: (i) a period of ten (10) years from the end of the final contract period of any government contract of **Aetna** to offer an **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)**, (ii) the date the U.S. Department of Health and Human Services, the Comptroller General or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. This section shall survive the termination of this **Group Agreement**, regardless of the cause of the termination.

**(C) Access to Information and Records.** **Contract Holder** agrees to provide **Us** and federal, state and local governmental authorities having jurisdiction, directly or through their designated agents (collectively “Government Officials”), upon request, access to all books, records and other papers, documents, materials and other information (including, but not limited to, contracts and financial records), whether in paper or electronic format, relating to the arrangement described in this **Group Agreement** (“Information and Records”). **Contract Holder** agrees to provide **Aetna** and Government Officials with access to Information and Records for as long as it is maintained as provided in “Information and Records” Section above. **Contract Holder** agrees to supply copies of Information and Records within fourteen (14) calendar days of **Contract Holder’s** receipt of the request, where practicable, and in no event later than the date required by an applicable law or regulatory authority. This section shall survive termination of this **Group Agreement**, regardless of the cause of termination.

- 5.2 **Access.** Make payroll and other records directly related to **Member’s** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder’s** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.
- 5.3 **Forms.** Distribute materials to **Aetna Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within no fewer than 10 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.
- 5.4 **Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.
- 5.5 **Written Notice to Members.** **Contract Holder** shall distribute to **Members** any written notice that **Aetna** provides to **Contract Holder** for distribution to **Members** (including, but not limited to, the Annual Notice of Change (ANOC) and any other written notice required under applicable laws) within the timeframe indicated by **Aetna**. **Contract Holder** will provide **Members** with written notice describing any changes made to **Member Premiums** or **Covered Benefits** at least thirty (30) days prior to the effective date of such change(s) or as required under applicable **Medicare** laws, rules and

regulations. **Contract Holder** will provide **Members** with any written notice required under applicable laws or policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. The written notices described in this section are hereinafter collectively referred to as the “**Written Notices**”. If **Contract Holder** does not distribute **Written Notices** to **Members** as required under this section, **Contract Holder** will be liable for payment of all **Member Premiums** or other costs incurred by **Aetna** as a result of **Contract Holder’s** failure to distribute the **Written Notices**. If **Contract Holder** does not distribute the **Written Notices** as required under this section, **Aetna** may, in its discretion, distribute such **Written Notices** to **Members**, and **Contract Holder** shall reimburse **Aetna** for any expenses incurred by **Aetna** in connection with such distribution.

**CMS** requires that all **Members** receive from **Aetna** a combined ANOC and EOC no later than the sooner of: (1) fifteen (15) days prior to the Open Enrollment Period, (2) October 31<sup>st</sup> of each calendar year, or (3) such shorter timeframe required under applicable laws, rules and regulations. To allow **Aetna** to comply with this **CMS** requirement, **Contract Holder** agrees to inform **Aetna** of its decision to renew or terminate the **Plan** (“Notice Date”) no later than the Notice Date set forth in the 2010 Plan renewal letter sent in calendar year 2009 by **Aetna** to **Contract Holder** (“Renewal Letter”).

- 5.6 **Member Plan Materials.** **Contract Holder** shall assure that any **Member Plan** materials that have not been approved by **CMS** comply with the following alternative disclosure standards: the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) or any alternative disclosure standards applicable to state or local entities that provide employee/retiree benefits.
- 5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports, unless **Contract Holder’s Plan** is specifically exempt thereunder.

## **SECTION 6. TERMINATION**

- 6.1 **Termination by Contract Holder.** This **Group Agreement** may be terminated by **Contract Holder** by providing **Us** with 60 days’s prior written notice. The notice of termination shall specify the effective date of such termination, which shall be on the 1<sup>st</sup> day of a calendar month and may not be less than 60 days from the date of the notice. Further, to allow **Aetna** to comply with **CMS** requirements, **Contract Holder** agrees to inform **Aetna** of its decision to renew or terminate the **Plan** as required under Section 5.5 of this **Group Agreement**.
- 6.2 **Renewal of Group Agreement.** This **Group Agreement** is renewable annually, unless **Aetna** will no longer offer any **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** in any service

areas covered under this **Group Agreement**, because: (1) **CMS** terminates or otherwise non-renews the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** contract with **CMS**, or (2) **Aetna** provides **CMS** with notice of its intention to non-renew its **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** contract or reduce the service areas referenced in its **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** contract with **CMS**.

6.3 **Termination by Us.** This **Group Agreement** may be terminated by **Aetna** by providing **Contract Holder** with 30 days' prior written notice if the **Member Premiums** owed by ten percent (10%) or more of **Members** remain unpaid at the end of the applicable **Grace Period**. The notice of termination shall specify the effective date of such termination.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;
- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the **Plan** who resides in the **Service Area**;
- Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our** contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by the Policies and Procedures; Compliance Verification section within a reasonable period of time specified by **Us**; (v) provides written notice to **Members** stating that coverage under this **Group Agreement** will no longer be provided to **Members**; or (vi) changes its eligibility or participation requirements without **Our** consent;
- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer a product or coverage in any market in which **Members** covered under this **Group Agreement** reside;
- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Centers for Medicare and Medicaid Services and consistent with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or by applicable federal rules and regulations, as amended; or
- Immediately upon notice to **Contract Holder** if **Contract Holder** is a member of an employer-based association group, and the **Contract Holder’s** membership in the association ceases.

- 6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**.
- 6.5 **Notice to Members.** It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws, **CMS** requirements and **Aetna's** policies and procedures. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **EOC** and applicable **CMS** requirements, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

It is also the responsibility of **Contract Holder** to notify **Members** of the involuntary termination of their coverage under the **Group Agreement** in compliance with all applicable laws, **CMS** requirements, and **Aetna's** policies and procedures. However, **We** reserve the right to notify **Members** of the involuntary termination of their coverage under the **Group Agreement** for any reason.

## **SECTION 7. PRIVACY OF INFORMATION**

- 7.1 **Compliance with Privacy Laws.** **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.
- 7.2 **Disclosure of Protected Health Information.** **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:
- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder's Plan** documents to incorporate the necessary changes required by such rule; or
  - provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.
- 7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a Member, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. **We** are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

## **SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS**

- 8.1 **Relationship Between the Parties.** The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

## **SECTION 9. MISCELLANEOUS**

- 9.1 **Delegation and Subcontracting.** **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, and quality assurance as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.
- 9.2 **Accreditation and Qualification Status.** **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.
- 9.3 **Prior Agreements; Severability.** As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.
- 9.4 **Amendments.** This **Group Agreement** may be amended as follows:
- This **Group Agreement** shall be deemed to be automatically amended to conform with all laws, rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
  - By written agreement between both **Parties**; or
  - By **Us** upon 30 days written notice to **Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us**

by making any other commitment or representation or by giving or receiving any information.

- 9.5 **Clerical Errors.** Clerical errors or delays by Us in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of **Premiums** shall be made. **We** may also modify or replace a **Group Agreement, EOC** or other document issued in error.
- 9.6 **Claim Determinations and Administration of Covered Benefits.** **We** have complete authority to review all claims for **Covered Benefits** as defined in the **EOC** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement, the EOC** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse **Our** discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing. The administration of **Covered Benefits** and of any appeals filed by **Members** related to the processing of claims for **Covered Benefits** shall be conducted in accordance with the **EOC** and any applicable laws, rules and regulations.
- 9.7 **Misstatements.** If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.
- 9.8 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:
- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
  - No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.
- 9.9 **Assignability.** No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **Aetna**.
- 9.10 **Waiver.** **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the

payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

- 9.11 **Notices.** Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.
- 9.12 **Third Parties.** This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.
- 9.13 **Non-Discrimination.** **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** of eligible individuals and eligible dependents based on health status or health risk.
- 9.14 **Applicable Law.** This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the applicable law, if any, of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.
- 9.15 **Inability to Arrange Services.** If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant number of **Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.
- 9.16 **Use of the Aetna Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.
- 9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Aetna** and **Contract Holder** arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the

American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We and Contract Holder** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Providers** shall not include **Aetna**. **Contract Holder** may not recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have followed the reviewer's decision. **Contract Holder** may not participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

- 9.18 **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases for **Members** who have outstanding Workers' Compensation claims involving the **Contract Holder**. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

- 9.19 **Electronic Enrollment and Disenrollment.** To the extent that the **Contract Holder** has elected to electronically enroll eligible employees and/or retirees and their eligible dependents ("**Eligible Party**" or "**Eligible Parties**") in the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** ("**Enroll**" or "**Enrollment**") and to electronically **Disenroll Members** from the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)**, and **Aetna** has agreed to accept **Enrollment** and **Disenrollment** information from **Contract Holder** through a roster and electronically process such **Enrollments** and **Disenrollments**, **Contract Holder** must meet certain administrative and legal requirements set forth in this section of this **Group Agreement**.

**Aetna** will electronically **Enroll Eligible Parties** who have elected the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** coverage ("**Electronic Enrollment**") and electronically **Disenroll Members** from the **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** ("**Electronic Disenrollment**"), provided **Contract Holder** meets the following requirements:

- Uses **Aetna** enrollment and **Disenrollment** forms approved by **CMS** for Electronic Enrollments and **Disenrollments** ("**Aetna Enrollment and Disenrollment Forms**"). As permitted under **Medicare** laws, rules and regulations and this **Group Agreement**, **Contract Holder** may permit **Eligible Parties** to electronically submit an election form to enroll in an **Aetna Medicare**

**Plan (“Online Enrollment Form”) to Contract Holder (“Online Election Process”).**

- Confirms that all **Aetna Enrollment and Disenrollment Forms** and **Online Enrollment Forms** contain all data required by **CMS**, prior to requesting that **Aetna** process any **Electronic Enrollments** or **Disenrollments**.
- Maintains and provides access to all original **Aetna Enrollment and Disenrollment Forms** and **Online Enrollment Forms** completed by **Eligible Parties** and **Members** in accordance with the Records section of this **Group Agreement** and all applicable **Medicare** laws, rules and regulations.
- Submits **Electronic Enrollment and Disenrollments** to **Aetna** timely and accurately in accordance with **Medicare** laws, rules and regulations, **Aetna** policies and procedures, and this **Group Agreement**.
- Submits to **Aetna** all data elements that are required by **CMS** and **Aetna** with respect to each **Electronic Enrollment** and **Disenrollment**, including, but not limited to, the following data elements:
  - Name
  - Permanent Address
  - Social Security Number
  - Medicare Claim Number (HICN)
  - Gender
  - Date of Birth
  - **Plan** Selection
  - Provider Selection (if applicable)
  - Group Number
  - Class Code
  - **Plan ID**
  - Effective Date

**Contract Holder** agrees to be bound by all laws, rules and regulations of, and all requirements applicable to, the arrangements described in this **Group Agreement**, including, without limitation, **CMS** requirements relating to **Electronic Enrollment and Disenrollment**. If **Aetna** determines, in its sole discretion and judgement, that the **Electronic Enrollment** or **Disenrollment** information provided by **Contract Holder** is incomplete, the **Electronic Enrollment** or **Disenrollment** will not be processed.

**Electronic Enrollments** deemed by **Aetna** to be complete will be processed by **Aetna** for the first of the month following receipt of the electronic file from **Contract Holder**. **Electronic Enrollments** may be processed 90 days retroactively from the current **CMS** effective cycle date when the following conditions apply:

- The requested effective date is indicated on the **Aetna Enrollment Form** or **Online Enrollment Form** completed by an **Eligible Party**, and on the electronic file transmitted by **Contract Holder** to **Aetna**; and
- The **Aetna Enrollment Form** is signed or the **Online Enrollment Form** is received by an **Eligible Party** prior to the requested effective date or prior to the date the **Aetna Enrollment Form** or **Online Enrollment Form** was completed by the **Eligible Party**.

**Electronic Disenrollments** deemed by **Aetna** to be complete will be processed by **Aetna** for the first of the month following receipt of the electronic file. **Aetna** will only process **Electronic Disenrollments** where an **Eligible Party** has voluntarily elected to **Disenroll** from an **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** by submitting a fully completed **Aetna Disenrollment Form** to **Contract Holder**. **Aetna** will not process **Electronic Disenrollments** where **Contract Holder** has elected to **Disenroll** an **Eligible Party** from an **Aetna Medicare Open<sup>SM</sup> Plan (PFFS)** due to **Eligible Party's** failure to pay **Plan** premium or any other basis.

**Contract Holder** will produce, at **Aetna's** request, the original copy of any **Aetna Enrollment** or **Disenrollment Form** or record of the **Online Enrollment Form** completed by an **Eligible Party**.

**Contract Holder** agrees that it will transmit to **Aetna** only that information which is reflected on an **Aetna Enrollment** or **Disenrollment Form** or **Online Enrollment Form** that is completed and signed, as required, by an **Eligible Party**.

**Contract Holder** agrees to obtain from **Eligible Parties** information, including authorizations, reasonably necessary for **Aetna** to perform its obligations under the arrangements set forth in this **Group Agreement**.

**Contract Holder** agrees to indemnify and hold **Aetna** harmless for any costs, expenses, claims or judgements, including attorney's fees that **Aetna** incurs as a result of **Contract Holder's** failure to comply with the terms of this section 9.19.

## **2010 Aetna Medicare Open<sup>SM</sup> Plan (PFFS) Evidence of Coverage**

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This plan is offered by Aetna Life Insurance Company (ALIC) referred throughout the *Evidence of Coverage* as “we,” “us,” or “our.” Aetna Medicare Open<sup>SM</sup> Plan (PFFS) is referred to as “plan” or “our plan.”

## 1: Introduction

This is your Evidence of Coverage, which explains how to get your Medicare medical health care coverage through our Plan, an Aetna Medicare Open<sup>SM</sup> Plan (PFFS). This Evidence of Coverage is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment record, and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called “riders” or “amendments.” This is an important legal document. 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. Please keep it in a safe place.

**You are still covered by Medicare, but you are getting your health care coverage through our Plan.**

**This Evidence of Coverage will explain to you:**

- What is covered by our Plan and what isn’t covered?
- How to get the care you need or your prescriptions filled, including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage.

**This Evidence of Coverage has important information about:**

- Eligibility requirements
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums, **if applicable**.
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

### **Your Eligibility Requirements**

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

If you are not entitled to Medicare Part A you may still be able to enroll in the Aetna Medicare Open<sup>SM</sup> Plan (PFFS) through special eligibility waiver. Your former employer or benefit administrator will advise you if this applies to you.

### **Membership Record Updates**

We maintain a membership record about you. Your membership record has information including your address and telephone number. It shows your specific Plan coverage, including the Primary Care Physician you chose and other information. Doctors, hospitals, pharmacists, and other network providers use your membership record to know what services or drugs are covered for you.

Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

### **Other Insurance Coverage You May Have**

Medicare requires that we collect information from you about any other medical or prescription drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. Once each year, we may 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 at the number on your plan membership card.

### **Materials You Will Receive**

#### **Plan Membership Card**

While you are a member of our Plan, you must use our plan membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items and drugs. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your plan membership card that we gave you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

### **Pharmacy Directory**

As a member of our Plan we will make available a complete Pharmacy Directory which gives you a list of our network pharmacies. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website [www.aetnamedicare.com](http://www.aetnamedicare.com).

### **List of Covered Drugs (Formulary)**

We call it the "Drug List" for short. It tells which Part D prescription drugs are covered. 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 Drug List. We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can call Member Services at the phone number on your plan membership card.

### **Summary of Payments Made for Your Prescription Drugs**

When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the Explanation of Benefits.

The Explanation of Benefits tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. An Explanation of Benefits summary is also available upon request. To get a copy, please contact Member Services.

### **Medicare & Plan Premium Responsibility**

As a member of our Plan, you pay:

- 1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount. (Your Part B premium is typically deducted from your Social Security payment.)
- 2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).
- 3) Your monthly plan premium, **if applicable**.

### **Plan Premium Payment Options**

If you have a premium and you are not billed by Aetna Medicare for your premium, please consult your benefits administrator for premium information.

If you have a premium and are billed directly by Aetna Medicare we will tell you in writing that if you don't pay your premium within the grace period noted on your bill, we will end your membership in our Plan.

### **Medicare Prescription Drug Plan Late Enrollment Penalty**

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 keep their coverage. For these members, the plan's monthly premium will be higher. 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.

### **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.

If you think you may qualify for Extra Help, call Social Security to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office. After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us. While you are at the pharmacy, you can ask the pharmacist to contact us at the number on your plan membership card. If the situation cannot be resolved at that time, we will give you a one-time exception and you will be charged the copayment/coinsurance amount that you were given by CMS. You will then have 21 days to submit your documentation. You can fax your evidence to 1-888-665-6296, or mail your documentation to:

Aetna Medicare Department  
Attention: BAE  
1425 Union Meeting Rd  
P.O. Box 963  
Blue Bell, PA 19422

Examples of evidence can be any of the following items:

- A letter from CMS auto assigning you to a Medicare Prescription Drug plan
- A letter from the Social Security Administration notifying you of your Low Income Subsidy award amount
- If you are in a Long Term care facility, we will need documentation from that facility noting payments made to them on your behalf by the state's Medicaid program
- A copy of a Medicaid card which includes your name and eligibility date during this period.
- A copy of a state document that confirms your active Medicaid status during this period.
- Other documentation provided by the state showing your Medicaid status during this period.

When we receive the evidence showing your copayment level, we will update our system or implement other procedures so that you can pay the correct copayment when you get your next prescription at the pharmacy. Please be assured that 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. Of course, 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.

If we do not receive documentation proving that you have qualified for extra help, and you are only charged the cost-sharing amount available to those eligible for extra help, we may contact you to recover any cost-sharing that you may owe.

**State Pharmaceutical Assistance Programs**

Many states have State Pharmaceutical Assistance Programs (SPAP) that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules. Check with your State Health Insurance Assistance Program. The name and phone numbers for this organization are provided in this booklet.

## **2: How to Get Your Medical and Prescription Drug Services & Exclusions**

### **Plan Coverage for Your Medical 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**

Providers is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

#### **Covered Services**

Covered is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. The amount you pay for covered services is listed in your Schedule of Copayments.

#### **How Providers Services Are Covered**

As a member of our Plan, you may get healthcare services from any provider, such as a doctor or hospital, in the United States who is eligible to be paid by Medicare and agrees to accept the plan's terms and conditions of payment prior to providing healthcare services to you. Not all providers may accept our plan's payment terms or agree to treat you. Therefore, you must show your plan membership ID card every time you visit a health care provider so that the provider is aware of your membership in a PFFS plan. There is a telephone number or website on the plan membership card for the provider to find out about our plan's terms and conditions of payment. This gives your provider the right to choose whether to accept our plan's terms and conditions of payment before treating you. The provider cannot change his/her mind about accepting the Plan's terms and conditions of payment after furnishing services. If you need emergency care, it is covered whether the provider agrees to accept the plan's payment terms or not.

If your provider agrees to accept our plan, then the provider must follow the plan's terms and conditions for payment, and bill the plan for the services they provide for you. You are only required to pay the copayment or coinsurance amount allowed by our plan at the time of the visit. A provider can decide at every visit whether or not to accept our plan's payment terms and agree to treat you.

As soon as you have told your provider that you are a member of our Plan (for example, by showing them your plan ID card) and they agree to treat you, your provider is bound by the terms and conditions of payment of the Plan even if they don't explicitly accept them. We call these providers "deemed providers".

If your provider doesn't agree to our plan's terms and conditions of payment, then the provider shouldn't provide services to you, except for emergencies. In this case, you will need to find another provider that will accept our plan's payment terms. If the provider chooses to treat you, then they may not bill you. They must bill the plan for your covered health care services. You are only required to pay the copayment or coinsurance amount allowed by the plan.

### **Provider Bills**

You should only pay the provider the cost-sharing allowed by our Plan as listed in your Schedule of Copayments. You should ask your provider to bill us for the rest of the fee and we will pay the provider according to our Plan's terms and conditions of payment. If the provider asks you to pay the full amount of the bill, and have you get paid back by the Plan, tell the provider that you only have to pay the cost-sharing amount. Your membership card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us at the telephone number or address on your plan membership card.

If you get a bill for the services, you may send the bill to us for payment. We will pay your provider for our share of the bill and will let you know if you must pay any cost-sharing. However, if you have already paid for the covered services we will reimburse you for our share of the cost.

If you have any questions about whether our plan will pay for a certain health care service, you can ask us for a written advance coverage decision before you get the service. We will let you know if our plan will pay for the service.

### **Medical Emergency**

When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much 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 our Member Services at the number on the back of your plan membership card.

You may get covered urgent and emergency medical care whenever you need it, worldwide. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health

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.

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.

If you decide to get follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible, by showing them your membership ID card. The plan will pay for all medically-necessary plan-covered services furnished by the provider and non-emergency care that you get from any provider in the United States who agrees to accept our plan's terms and conditions of payment.

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

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 so that we can pay our share of the costs for your covered medical 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 ; see section *Reimbursement From Our Plan* for information about what to do.

### **Cost for Services Not Covered By Plan**

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren't medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn't medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you didn't ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

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

### **Clinical Trial**

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it’s a “qualified” clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren’t in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan.

You don’t need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don’t need to be network providers. However, please be sure to tell us before you start participation in a clinical trial so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication “Medicare and Clinical Trials” at [www.medicare.gov](http://www.medicare.gov) under “Search Tools” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **Religious Non-medical Health Care Institutions**

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of “non-excepted” medical treatment. (“Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. “Non-excepted” medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan.

### **Medicare Covered Services/Medical Benefits**

Your plan coverage includes all Medicare medical covered services. These are the benefits and coverage you get as a member of our Plan (see below).

Below are definitions you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The “**deductible**” means the amount you must pay for medical services before our plan begins to pay its share.
- A “**copayment**” means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- “**Coinsurance**” means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.
- In addition to collecting applicable plan cost sharing amounts from members, providers that do not accept assignment with Original Medicare may balance bill the member up to 15% of the total plan payment amount for the service(s) furnished. Note that Aetna Medicare Open Plan PFFS does not permit a provider to balance bill a member who is also enrolled in a state Medicaid program and as a result the beneficiary is held harmless from Medicare cost sharing.
- Depending upon the plan option selected by your former employer, there may be a limit to how much you have to pay out-of-pocket for certain covered health care services each year. After this level is reached, you will have 100% coverage and

not have to pay any out of pocket costs for the remainder of the year for covered services. Refer to your Schedule of Copayments for details.

- A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [www.aetnamedicare.com](http://www.aetnamedicare.com).

**Please refer to your Schedule of Copayment for what you pay for each service and any additional services that may be offered. The Schedule of Copayments provides a listing of covered benefits, including, where applicable, those additional benefits purchased by your former employer.**

The covered services listed in the Schedule of Copayments Payments are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary.
- Certain preventive care and screening tests are also covered.
- Certain kinds of benefits are **excluded** from Medicare medical coverage (see below).

## **Medicare Covered Benefits**

### **Inpatient Hospital Care**

*Medicare covered services include no limit to the number of days covered by the plan for each benefit period;*

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications

- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Physician Services

### **Inpatient Mental Health Care**

Medicare covered services include mental health care services that require a hospital stay. 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.

### **Skilled Nursing Facility (SNF) Care**

Medicare covered services include 100 days covered for each benefit period. No prior hospital stay is required.

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, and speech therapy

- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services
- Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment.
- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

### **Home health agency care**

Medicare covered services include:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical social services
- Medical equipment and supplies

## **Hospice care**

Medicare covered services include care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan
- Home care

Hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

## **Physician services, including doctor office visits**

Medicare covered services include:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center
- Consultation, diagnosis, and treatment by a specialist
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment
- Telehealth office visits including consultation, diagnosis and treatment by a specialist
- Second opinion by another network provider prior to surgery
- Outpatient hospital services
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)

## **Chiropractic services**

Medicare covered services include: manual manipulation of the spine to correct subluxation.

**Podiatry services**

Medicare covered services include treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care for members with certain medical conditions affecting the lower limbs.

**Outpatient mental health care (including Partial Hospitalization Services)**

Medicare covered services include Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.

**Outpatient substance abuse services****Outpatient surgery (including services provided at ambulatory surgical centers).****Ambulance services**

Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required

**Emergency care****Urgently needed care****Outpatient rehabilitation services**

Medicare covered services include physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy

**Durable medical equipment and related supplies**

Medicare covered items include wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.

**Prosthetic devices and related supplies**

Other than dental, that replaces a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of

prosthetic devices. Also includes some coverage following cataract removal or cataract surgery.

### **Diabetes self-monitoring, training and supplies**

Medicare covered services include for people who have diabetes (insulin and non-insulin users):

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
- One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts
- Self-management training is covered under certain conditions
- For persons at risk of diabetes: Fasting plasma glucose tests, as medically necessary

### **Medical nutrition therapy**

Medicare Covered services include for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.

### **Outpatient diagnostic tests and therapeutic services and supplies**

Medicare Covered Services include:

- X-rays
- Complex imaging such as: MRI, MRA, PET scan.
- Radiation therapy
- Surgical supplies, such as dressings
- Supplies, such as splints and casts
- Laboratory tests
- Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need.
- Other outpatient diagnostic tests

## **Vision care**

Medicare covered services include:

- Outpatient physician services for eye care.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant

## **Preventive Care and Screening Tests**

### **Abdominal Aortic Aneurysm Screening**

Medicare covered services include a one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.

### **Bone-mass measurements**

Medicare covered services include for qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results

### **Colorectal screening**

Medicare covered services include:

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months
- Fecal occult blood test, every 12 months

For people at high risk of colorectal cancer, we cover:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy

### **Immunizations**

Medicare covered services include:

- Pneumonia vaccine
- Flu shots, once a year in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- Other vaccines if you are at risk

(Some vaccines are covered under the Medicare Prescription Drug Plan Benefit).

### **Mammography screening**

Medicare covered services include:

- One baseline exam between the ages of 35 and 39
- One screening every 12 months for women age 40 and older

### **Pap tests, pelvic exams, and clinical breast exam**

Medicare covered services include:

- For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months
- If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months

### **Prostate cancer screening exams**

Medicare covered services include for men age 50 and older, the following once every 12 months:

- Digital rectal exam
- Prostate Specific Antigen (PSA) test

### **Cardiovascular disease testing**

Medicare covered services include blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease), as medically necessary

### **Physical exams**

Medicare covered services include a one-time physical exam for members within the first 12 months that they have Medicare Part B. Includes measurement of height, weight, body mass index and blood pressure; end-of-life planning; education, counseling and

referral with respect to covered screening and preventive services. Routine annual physical exam (doesn't include lab tests).

### **Dialysis (Kidney)**

Medicare covered services include:

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area).
- Inpatient dialysis treatments (if you are admitted to a hospital for special care)
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

### **Medicare Part B Prescription Drugs**

These drugs are covered under Part B of the Original Medicare Plan.

- Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp® and Darbepoetin Alfa)

- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

### **Dental Services**

Medicare covered service by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor

### **Hearing Services**

Medicare covered service include annual diagnostic hearing exam

### **Medicare Excluded Plan Benefits**

Excluded means that the plan does not cover these benefits. The list below describes a general list of some services and items that are not 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 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.

- 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. However, certain services may be covered under a Medicare-approved clinical research study.
- 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
- 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 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, filings or dentures. However, non-routine dental care received at a hospital may be covered.
- 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
- 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 and routine hearing examinations
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy
- 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.

Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

**Note: See Schedule of Copayments for a listing of covered benefits; some employer group plans purchase additional plan benefits.**

## **Part D Prescription Drug Coverage**

This section explains rules for using your coverage for your pharmacy benefit, also referred to in this document as Part D drugs. The amount you pay for covered drugs is listed in the Schedule of Copayments.

In addition to your coverage for Part D drugs, Aetna Medicare PFFS 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 Schedule of Copayment 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 Schedule of Benefits tells about the benefits and costs for Part B drugs and what you pay.

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.

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

- You must use a network pharmacy to fill your prescription.
- Your drug must be on the plan's Drug List of Covered Drugs (Formulary).
- Your drug must be considered "medically necessary," meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

In most cases, your prescriptions are covered only if they are filled at the plan's 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 by the plan.

### **Finding Network Pharmacies**

You can look in your Pharmacy Directory, visit our website [www.aetnamedicare.com](http://www.aetnamedicare.com) or call Member Services at the number on your plan membership 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 to either have a new prescription written by a doctor or to have your prescription transferred to your new network pharmacy.

If the pharmacy you have been using leaves the plan’s network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services or use the Pharmacy Directory.

### **Non-retail, Network Pharmacies**

Sometimes prescriptions must be filled at non-retail, network pharmacy. These 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 certain drugs that are restricted by the FDA to certain locations require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate one of these pharmacies, look in your Pharmacy Directory or call Member Services at the number on your plan membership card.

### **Mail Order**

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 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 7-10 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.

### **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 "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan's network mail-order services. These drugs are marked as maintenance drugs on our plan's Drug List. Our plan's mail-order service requires you to order up to a 90-day supply.

### **Out of Network**

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

- If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost.
- 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 distances 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.

### **Drug List (Formulary)**

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.

We will generally cover a drug on the plan’s Drug List as long as you follow the other coverage rules explained in this section and the drug is medically necessary, meaning reasonable and necessary for treatment of your injury or illness. It also needs to be an accepted treatment for your medical condition.

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. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

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.
- In other cases, we have decided not to include a particular drug on the Drug List.

### **Cost Sharing Tiers**

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

To find out which cost-sharing tier your drug is in, look it up in the plan’s Drug List (Formulary). The amount you pay for drugs in each cost-sharing tier is shown in the Schedule of Copayments.

To 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.
2. Visit the plan's website [www.aetnamedicare.com](http://www.aetnamedicare.com) . The Drug List on the website is always the most current.
3. Call Member Services at the number listed on your plan membership card to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

### **Drug 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. 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 doctor to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

The plan's Drug List includes information about the restrictions described below. 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 at the number on your plan membership card or check our website at [www.aetnamedicare.com](http://www.aetnamedicare.com).

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 may use for certain drugs.

### **Using Generic Drugs Whenever You Can**

A "generic" drug works the same as a brand-name drug, but usually costs less. When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version. However, if your doctor 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.)

### **Advance Approval**

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "prior authorization." Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. 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 safer or more 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.

### **If Your Drug Is Not Covered**

Suppose there is a prescription drug you are currently taking, or one that you and your doctor 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. 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.
- 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 different cost-sharing tier. 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;
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be.

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).
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug in the way you would like it to be covered.

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List (Formulary) or when it is restricted in some way. Doing this gives you time to talk with your doctor 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
  
2. You must be in one of the situations described below:
  - 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 31 days or less if your prescription is written for fewer days.
  - For those who are new members, and are residents 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 31 days, 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.
  - Current members with a level of care changes are eligible for an emergency supply of each prescription, up to a 31-day supply (unless the prescription is written for fewer days).
  - To ask for a temporary supply, call Member Services at the number listed on your plan membership card.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor 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 doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

### **You can change to another drug**

Start by talking with your doctor. 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 doctor to find a covered drug that might work for you.

### **You can file an exception**

You and your doctor 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 doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber 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 (Formulary). Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

### **Drug List Changes**

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
- 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 (Formulary).

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

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 doctor to switch to the generic or to a different drug that we cover.
  - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you.
- 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 doctor will also know about this change, and can work with you to find another drug for your condition.

## **Drug Types Not Covered**

This section tells you what kinds of prescription drugs are “excluded.” Excluded means that the plan doesn’t cover these types of drugs because the law doesn’t allow any Medicare drug plan to cover them. 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 (unless our plan covers certain excluded drugs). 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 because of your specific situation.

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.
- 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 unless we offer enhanced drug coverage.**

- 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 former employer may offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.

In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for the drugs not normally covered. Please refer to your drug list (formulary) or call Member Services for more information. However, 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, if you are eligible for Medicaid benefits.

### **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.

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.

### **Special Situations**

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

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.

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.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber 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 doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered.

### **Drug Safety Programs**

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 doctor to correct the problem.

## **Managing 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 your participation in the program.

## **What You Pay For Your Prescription Drugs**

To keep things simple, we use “drug” to mean a Part D prescription drug. As explained some drugs are covered under Original Medicare or are excluded by law. Some excluded drugs may be covered by our plan if purchased by your previous employer.

To understand the payment information, 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:

### **Drug List (Formulary)**

This Drug List tells which drugs are covered for you. It also tells which of the “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 at the phone number on your plan membership card. You can also find the Drug List on our website at [www.aetnamedicare.com](http://www.aetnamedicare.com). The Drug List on the website is always the most current.

### **Pharmacy Directory**

In most situations you must use a network pharmacy to get your covered drugs. The Pharmacy Directory has a list of pharmacies in the plan’s network and it tells how you can use the plan’s mail-order service to get certain types of drugs. 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).

### **Summary of Payments Made for Your Prescription Drugs**

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. 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 drug costs, what the plan paid, and what you and others on your behalf paid.
- Totals for the year since January 1. This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

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 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.) 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.
- Check the written report we send you. When you receive an Explanation of Benefits 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 at the number listed on your plan membership card. Be sure to keep these reports. They are an important record of your drug expenses.

## 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

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

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.):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage.
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year under another 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, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help".

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

- The amount you pay for your monthly premium, if applicable.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.

- Drugs you get at an out-of-network pharmacy that do not meet the plan’s requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- 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.
- Payments for your drugs that are made by another employer group health plan.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE, the Veterans Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker’s 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 at the number listed on your plan membership card.

### **Tracking Your Out-Of-Pocket Total**

We will help you. The Explanation of Benefits report we send to you includes the current amount of your out-of-pocket costs. When you reach a total of \$4,550 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.

### **Vaccinations**

Our plan provides coverage of a number of vaccines. There are two parts to our coverage of 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 you pay for a vaccination depends on three things:

1. The type of vaccine (what you are being vaccinated for).
  - Some vaccines are considered medical benefits.
  - Other vaccines are considered Part D drugs.

- You can find these vaccines listed in the plan's List of Covered Drugs.
2. Where you get the vaccine medication.
    - You can then ask our plan to pay our share of the cost by using the procedures under *Reimbursement from Our Plan* discussed later in this booklet.
  3. Who gives you the vaccination shot?

What you pay at the time you get the 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 vaccination shot:

Situation 1: You buy the 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 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 this booklet (*Asking the plan to pay its share of a bill you have received for 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 amounts the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the 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 your appropriate 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.
- You will be reimbursed the amount charged by the doctor less any cost-sharing amount that you need to pay for the vaccine less any difference between the amounts the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

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.

- 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.

#### **Part D Late Enrollment Penalty**

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 keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your premium. When you first enroll, we let you know the amount of the 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 credible 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 our example, let's say it is 14 months without coverage, which will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents

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 Medicare.

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

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:

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "creditable drug coverage." Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is at least as good as Medicare's.

- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) – and – you signed up for a Medicare prescription drug plan by December 31, 2006 – and – you have stayed in a Medicare prescription drug plan.
- You are receiving “Extra Help” from Medicare.

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Member Services at the number on the front of this booklet to find out more about how to do this.

### **Reimbursement from Our Plan**

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 emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed 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.

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

4. 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.

5. 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

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

**Medical:**

See the address on your plan membership card

**Prescription Drugs:**

Aetna Medicare Prescription Drug Claim Processing Unit  
P.O. Box 14023  
Lexington KY 40512

Please be sure to contact Member Services if you have any questions. If you don't know what you owe, 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.

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 decide whether to pay it and how much we owe.

- 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.
- 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.

- If you think we have made a mistake in turning down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a legal process with detailed procedures and important deadlines

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 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 the plan's price

Sometimes when you are in the Deductible Stage and Coverage Gap Stage you can buy your drug at a network pharmacy for a price that is lower than the plan's price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

**Please note:** If you are in the Deductible Stage and Coverage Gap Stage, the plan will not pay for any share of these drug costs. But sending 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, the plan will not pay for any share of these drug costs. But sending 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.

### **3: Your Rights and Responsibilities**

#### **Our plan must honor your rights as a member of the plan**

We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services at the phone number on your plan membership card.

Our plan has people and translation 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 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 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.

#### **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, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

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 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 cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

#### **We must ensure that you get timely access to your covered services and drugs**

You may seek care from any provider in the United States who is eligible to be paid by Medicare and agrees to accept our plan's terms and conditions of payment. You should always (except possibly in emergencies) show the provider your PFFS plan membership card. If the provider treats you, the provider becomes a "deemed provider," meaning that the provider is now bound to abide by our rules even if the provider did not read our terms and conditions of payment. As a plan member, you have the right to get appointments and covered services from providers within a reasonable amount of time.

## **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”, which 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.

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 consider your request and 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.

**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, 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:

- 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 Advantage health plans.
- **Information about your coverage and rules you must follow in using your coverage.**
  - In 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 see the plan's List of Covered Drugs (Formulary). This Evidence of Coverage, together with the List of Covered Drugs, 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
- **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.
- 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

**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.

**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.
- 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 the state specific agency (such as the State Department of Health).

**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, this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services at the number located on your plan membership card.

**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.

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 at the phone number on your plan membership card.
- You can call the State Health Insurance Assistance Program

**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 (number is listed on your plan membership card).
- You can call the State Health Insurance Assistance Program.
- You can contact Medicare.

- You can visit the Medicare website (<http://www.medicare.gov>) to read or download the publication “Your Medicare Rights & Protections.”
- 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.

## **You Have Some Responsibilities as a Member of the Plan**

### **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. 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.
- If you have any other health insurance coverage or prescription drug coverage besides 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.
- 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.
  - 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:
  - If applicable, you must pay your plan premiums to continue being a member of our 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). See your Schedule of Copayments.
  - 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 are going to move, it's important to tell us right away. Call Member Services, we need to keep your membership record up to date and know how to contact you.
  - If you move outside of our plan service area, you generally cannot remain a member of our plan. We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.
- Call member services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are on your plan membership card. For more information on how to reach us, including our mailing address, please see your plan membership card.

## 4: Coverage Decisions, Appeals, Complaints

### **Introduction**

Please call us first. Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Member Services at the phone number on your plan membership card. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare.

We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

**This section explains two types of formal processes for handling problems:**

- 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.

### **Legal Terms**

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

To keep things simple, this section explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this section 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.

## **You can get help from government organizations that are not connected with us.**

### **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. Perhaps both are true for you.

### **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. This government program has trained counselors in every state. The program is not connected with our plan 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. Their services are free. You will find phone numbers in the back 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>).

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

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 and you want to do something about it, you don't need to read this whole section. You just need to find and read the parts of this section that apply to your situation.

## **A guide to the basics of coverage decisions and appeals**

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. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, 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:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.
- But in some cases we might decide the 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 being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. 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.

### **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 cover).

- To get free help from an independent organization that is not connected with our plan, contact your State Health Insurance Assistance Program
- You should consider getting your doctor or other provider involved if possible, especially if you want a “fast” or “expedited” decision. In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can’t request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your “representative” (see below about “representatives”).
- 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 form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan 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.

### **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.

If you’re still not sure which you should be using, please call Member Services (phone numbers are on your plan membership card). You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

### **Your medical care: How to ask for a coverage decision or make an appeal**

This section is about your benefits for medical care and services. 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 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 because special rules apply to these types of care.

Here's what to read in those situations:

- Section: How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.
- Section: How to ask our plan 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 as your guide for what to do.



### **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 Term--A coverage decision is often called an “initial determination” or “initial decision.” When a coverage decision involves your medical care, the initial determination 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 Term--A “fast decision” is called an “expedited decision.”*

How to request coverage for the medical care you want

- Start by writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.

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 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).
- 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 days if we find that some information is missing that may benefit you, or if you need 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, please refer to that section in this booklet. 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, our plan 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.

**Step 2: Our plan considers your request for medical care coverage and we 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 days under certain circumstances. If we take extra days, it is called “an extended time period.”
  - 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.

- 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 days (“an extended time period”) under certain circumstances.
  - 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.
- 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.

<p><b>Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.</b></p>
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- If our plan says 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 appeal, it means you are going on to Level 1 of the appeals process (see below).



<p><b>Step-by-step: How to make a Level 1 Appeal</b></p>
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*How to ask for a review of a medical care coverage decision made by our plan*

*Legal Term-When you start the appeal process by making an appeal, it is called the “**first level of appeal**” or a “Level 1 Appeal.”*

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

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

What to do

- To start an appeal you, your representative, or in some cases your doctor must contact our plan. For details on how to reach us for any purpose related to your appeal, refer to the section “How to contact our plan when you are making an appeal about your medical care”.
- Make your standard appeal in writing by submitting a signed request. You may also ask for an appeal by calling us, see *Helpful Phone Numbers and Resources* at the back of this booklet.
- 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.
- You can ask for a copy of the information in your appeal and add more information if you like.
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make an oral request)

*Legal Term-A “fast appeal” is also called an “expedited appeal.”*

- If you are appealing a decision our plan 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 automatically agree to give you a fast appeal.

**Step 2: Our plan considers 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 being fair and 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 days.
  - 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 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.
- 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 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 days.

- 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 sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

- To make sure we were being fair when we said no to your appeal, our plan is 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.



### **Step-by-step: How to make a Level 2 Appeal**

If our plan says 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 our plan 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 outside, 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.
- 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, 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 days.

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

- If you made a standard appeal to our plan at Level 1, 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 days.

<p><b>Step 2: The Independent Review Organization gives you their answer.</b></p>
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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 days after we receive the decision from the review organization.
- If this organization says no to your appeal, it means they agree with our plan that 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 notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing 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.

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

**Asking for reimbursement is asking for a coverage decision from our plan**

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

**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. 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.

- 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.

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

*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 they are medically necessary for you, as determined by your primary care doctor or other provider.

- **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, rules and restrictions on coverage, and cost information.

### **Part D coverage decisions and appeals**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

*Legal Term-A coverage decision is often called an “initial determination” or “initial decision.” When the coverage decision is about your Part D drugs, the initial determination 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
  - 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 but we require you to get approval from us before we will cover it for you.)
- 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 this guide to help you determine which part has information for your situation:

### **What is an exception?**

If a drug is not covered in the way you would like it to be covered, you can ask the plan 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.

### **1. Covering a Part D drug for you that is not on our plan’s List of Covered Drugs (Formulary).** (We call it the “Drug List” for short.)

*Legal Term-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 the highest tier, including the high cost specialty tier (if applicable). You cannot ask for an exception to the copayment or co-insurance 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.

### **2. Removing a restriction on the plan’s coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on the plan’s List of Covered Drugs.**

*Legal Term-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:
  - Being required to use the generic version of a drug instead of the brand-name drug.
  - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier. Every drug on the plan’s Drug List is in 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 Term-Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “**tiering exception.**”*

- If your drug is in the highest tier subject to the tiering exceptions process, you can ask us to cover it at the cost-sharing amount that applies to drugs in the next lower tier. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any of the drugs in the Specialty Prescription Drug Tier, when it is included as part of your plan design

**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 written 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.

### **Our plan 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.

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



### **Step-by-step**

### **How to ask for a coverage decision, including an exception**

**Step 1: You ask our plan 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 our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this.
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. This section 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 our plan to pay you back for a drug, refer to the section “Reimbursement From our Plan” covered earlier in this booklet.
- 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 our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement.

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

*Legal Term-A “fast decision” is called an “expedited 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 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), our plan 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).

**Step 2: Our plan considers 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

- 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 we approve your request to pay you back for a drug you already bought, we are also required to send payment to you within 30 calendar days 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.

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

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



**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 Term-When you start the appeals process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”*

An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

**Step 1: You contact our plan 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 our plan.
  - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to “Helpful Numbers and Resources” section in the back of this booklet.
- Make your appeal in writing by submitting a signed request
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer 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.
- You can ask for a copy of the information in your appeal and add more information.
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

*Legal Term-A “fast appeal” is also called an “expedited appeal.”*

- If you are appealing a decision our plan 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.

<b>Step 2: Our plan considers your appeal and we give you our answer.</b>
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- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and 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.
- 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 we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is yes to part or all of what you requested –
  - If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

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

- If our plan says 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).



### **Step-by-step How to make a Level 2 Appeal**

If our plan says 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 our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

*Legal Term-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 our plan says 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.

<p><b>Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.</b></p>
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- The Independent Review Organization is an outside, 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 review our decisions about your Part D benefits with our plan.
- 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 if the dollar value of the coverage you are requesting is high enough 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 section tells more about Levels 3, 4, and 5 of the appeals process.

**How to ask us to cover a longer 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 the plan’s coverage for your hospital care, including any limitations on this coverage, see your Schedule of Copayments.

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.

**During your 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 is supposed to give it to you within two days after you are admitted.

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.
  - What to do if you think you are being discharged from the hospital too soon.

*Legal Term-The written notice from Medicare tells you how you can “**make an appeal.**” Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time.*

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.
  - 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 or TTY: 1-877-486-2048). You can also see it online at <http://www.cms.hhs.gov>



### **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 our plan 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. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance; see Helpful Phone Numbers and Resources at the back of this booklet.

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.

*Legal Term-When you start the appeal process by making an appeal, it is called the “**first level of appeal**” or a “**Level 1 Appeal**.”*

**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 Term-A “fast review” is also called an “immediate review” or an “expedited 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) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in 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.

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 Term-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 our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

*Legal Term-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, our plan 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.

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. (Saying no to your appeal is also called turning down your appeal.) If this happens, our plan’s 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 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.



### **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.

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 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 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

If the review organization says yes:

- Our plan 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. Our plan 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 to your Level 1 Appeal and will not change it. This is called “upholding the decision.” It is also called “turning down your appeal.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by 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.

### **What if you miss the deadline for making your Level 1 Appeal?**

#### **You can appeal to our plan instead**

As explained above, 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 our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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

**Step 1: Contact our plan and ask for a “fast review.”**

- For details on how to contact our plan, please refer to Helpful Phone Numbers and Resources at the back of this booklet.
- 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: Our plan does a “fast” review of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, our plan takes 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: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- If our plan says 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 our plan says 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 our plan says 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 being fair when we said no to your fast appeal, our plan is 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 our plan says 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 our plan made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

*Legal Term-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.

### **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 outside, 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 our plan 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 our plan that your planned hospital discharge date was medically appropriate. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

- 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.

**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***

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 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 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.

When our plan decides 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, our plan will stop paying its 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.

**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 notice.
  - The written notice tells you the date when our plan will stop covering the care for you.

*Legal Terms-In this written notice; we are telling you about a “coverage decision” we have made about when to stop covering your care*

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 Term-In telling what you can do, the written notice is telling how you can “make an appeal.” Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care.*

*Legal Term-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.



**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).
- 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 front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see *Helpful Phone Numbers and Resources* at that back of this booklet).

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

*Legal Terms-When you start the appeal process by making an appeal, it is called the “first level of appeal” or “Level 1 Appeal.”*

<p><b>Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.</b></p>
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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; see *Helpful Resources and Phone Numbers* in 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 our plan 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 our plan instead.

**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.
- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan’s coverage for your services.

*Legal Term-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 our plan 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.

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. Our plan will stop paying its 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.



**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.

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?

- Our plan must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. Our plan 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 they made to your Level 1 Appeal and will not change it. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by 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 whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

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

**You can appeal to our plan instead**

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.



### **Step-by-Step How to make a Level 1 Alternate Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, 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” review (or “expedited appeal”).*

**Step 1: Contact our plan and ask for a “fast review.”**

- For details on how to contact our plan, please refer to *Helpful Numbers and Resources* at the back of this booklet.
- 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: Our plan does a “fast” review of the decision we made about when to stop coverage for your services.**

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and 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: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- If our plan says 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 our plan says no to your fast appeal, then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its 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 would end, then you will have to pay the full cost of this care yourself.

**Step 4: If our plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process.**

- To make sure we were being fair when we said no to your fast appeal, our plan is 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 our plan says 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 our plan 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.)

### **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 outside, 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 our plan 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. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

- 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.

### **Taking your appeal to Level 3 and beyond**

#### **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 answer is yes, 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 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, 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. It depends on your situation. 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 stage of the appeals process.**

- This is the last step of the administrative appeals process.

**Levels of Appeal 3, 4, and 5 for Part D Drug Appeals**

This section may be appropriate for 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.
- 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 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.
- 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. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of 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 stage of the appeals process.**

- This is the last step of the administrative appeals process.

## **MAKING COMPLAINTS**

**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.

**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.

**The formal name for “making a complaint” is “filing a grievance”**

*Legal Term-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.”*



### **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. See the Member Services phone number on your plan membership card.
- 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 do this, it means that we will use our formal procedure for answering grievances. Here’s how it works:
- Send your written complaint to the address listed at the back of this booklet; refer to Helpful Phone Numbers and Resources. 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 the extension, or if we justify a need for additional information and the delay is in your best interest.

- You also have the right to ask for a fast “expedited” grievance. 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 the phone number in the back of this booklet (refer to Helpful Phone Numbers and Resources) or fax or write your complaint and send it to the address listed in the back of this booklet (refer to Helpful Phone Numbers and Resources). 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 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 a “fast 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 days, but we may take up to 44 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 days (44 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.

**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 our plan 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 our plan). The name, address, and phone number of the Quality Improvement Organization in your state have been included in this booklet. If you make a complaint to this organization, we will work together 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 our plan and also to the Quality Improvement Organization.

## 5: Ending Your Membership

It is important that you consider your decision to disenroll in our plan carefully PRIOR to disenrolling. Since disenrollment in our plan could affect your employer or union health benefits, you could lose your employer or union health coverage. If you have not done so already, please contact your benefits administrator.

Ending your membership 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.
- There are also limited situations where you do not choose to leave, but we are required to end your membership
- If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.
- If you join another Medicare Advantage Plan with Prescription Drug, you will be automatically disenrolled from our plan. Once you have voluntarily disenrolled in our plan, we cannot retro-actively re-enroll you.

Because of your special situation (enrollment through your former employer's or union's group plan) you are eligible to end your membership during a Special Election Period. By ending your membership because of this special situation, you can choose to change both your Medicare health coverage and prescription drugs. This means you can choose any of the following type plans:

- Another Medicare Advantage 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.

**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. (“Creditable” coverage means the coverage is at least as good as Medicare’s standard prescription drug coverage.)

Your membership will usually end on the first day of the month after we receive your request to change your plan.

If you have any questions or would like more information on when you can end your membership:

- You can call Member Services at the number on your plan membership card.
- You can find the information in the Medicare & You 2010 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.

If you leave our plan it may take time before your membership ends and your new Medicare coverage goes into effect. 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, you will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

**We 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 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.
- We must notify you in writing that you have a grace period to pay the plan premium before we end your membership.
- If your former employer terminates or non-renews its group coverage with Aetna Medicare

If you have questions or would like more information on when we can end your membership you can call Member Services for more information.

**We cannot ask you to leave our plan for any reason related to your health.**

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.

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.

## 6: Legal Notices

### **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.

### **Notice about nondiscrimination**

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug 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.

### **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 us and will only include the participating provider subject to this allegation. Members waive their right to bring any claim against us 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 us.

Unless otherwise agreed by the parties to the arbitration, all disputes shall be submitted to neutral arbitration within the Plan 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 plan membership card.

**Notice about subrogation and right of recovery**

If the Plan provides health care benefits under this Evidence of Coverage to a member for injuries or illness for which another party is, or may be responsible, then we retain the right to repayment of the full cost of all benefits provided by us on behalf of the member. Our rights of recovery apply to any recoveries made by or on behalf of the member from the following sources:

- Payments made by a third party, or any other insurance company on a third person's behalf
- Payments or awards under an uninsured or underinsured motorist coverage policy
- Any Workers' Compensation or disability award or settlement
- Medical payments coverage under any automobile policy
- Premises or homeowners medical payments coverage or insurance coverage
- Any other payments from a source intended to compensate a member for injuries resulting from an accident or alleged negligence.

By providing any benefit under this Evidence of Coverage, we are granted an assignment of the proceeds of any settlement, judgment, or other payment received by the member to the extent of the full cost of all benefits provided by the Plan.

**You and your representatives further agree to:**

- A. Notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by you that may be the legal responsibility of another party;
- B. Cooperate with us and do whatever is necessary to secure our rights of subrogation and/or reimbursement under this Evidence of Coverage;

- C. Give us a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with injuries or illness provided by the Plan for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due the Plan as reimbursement for the full cost of all benefits associated with injuries or illness provided by us for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing; and
- E. Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by the Plan.

We may recover the full cost of all benefits provided by the Plan under this Evidence of Coverage without regard to any claim of fault on the part of you, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from our recovery without the prior express written consent from us. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits paid by the Plan in addition to costs and attorney's fees incurred by us in obtaining repayment.

**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, we have 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 our discretion. You shall execute any documents and cooperate with us to secure our right to recover such overpayments, upon request by us.

## 7: Definitions of Important Words Used in the EOC

**Appeal** – An appeal is something you do if you disagree with a decision to deny a request for 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 a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive.

**Benefit Period** – Under Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

**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 \$ 4550.00 in covered drugs during the covered year.

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

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

**Cost-sharing** – Cost-sharing refers to amounts that a member has to pay when drugs or services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed “copayment” amounts that a plan may require be paid when specific drugs or services are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid for a drug or service.

**Cost-sharing Tier** – Every drug on the list of covered drugs is in 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 medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or 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 if you disagree.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our Plan.

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

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to cover, 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** – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don’t have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

**Deductible** – The amount you must pay before our plan begins to pay its share of your covered medical services or drugs.

**Disenroll or Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Durable Medical Equipment** – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

**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).

**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, generic drugs cost less than brand-name drugs.

**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 after you have met your deductible and before your total drug expenses, have reached the coverage limit, including amounts you’ve paid and what our Plan has paid on your behalf.

**Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects 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.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of covered drugs provided 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/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.

**Medically Necessary** – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage).

These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

**Member (Member of our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network 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.”

**Non-preferred Network Pharmacy OR Other Network Pharmacy** – A network pharmacy that offers covered drugs to members of our Plan at higher cost-sharing levels than apply at a preferred network pharmacy.

**Optional Supplemental Benefits** – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium.

**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.

**Original Medicare** (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care provider’s payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-network Provider or Out-of-network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you.

**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.

**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.

**Primary Care Physician (PCP)** – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member.

**Preferred Provider Organization Plan** – A Preferred Provider Organization plan is an MA 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.

**Prior Authorization** – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our Plan. Covered services that need prior authorization are marked in the Benefits Chart. 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)** – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers.

**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** – “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

**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 a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

## **8: Helpful Phone Numbers and Resources**

### **Contact Information for our Plan Member Services**

**If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.**

**CALL**        *See Plan Membership Card*

**WRITE**        Aetna Medicare  
P.O. Box 963  
Blue Bell, PA 19422

**WEBSITE**    [www.aetnamedicare.com](http://www.aetnamedicare.com)

### **Organization Determinations (about your Medicare Care and Services)**

**CALL**        1-800-282-5366 (Calls to this number are free).  
7 days per week, 24 hours per day.  
1-800-932-2159 for expedited requests.

**TTY/TDD**    1-888-760-4748 (This number requires special telephone equipment;  
calls to this number are free).

**WRITE**        Aetna Medicare  
Attention: Precertification Unit  
151 Farmington Avenue  
Hartford, CT 06156

### **Grievances (about your Medical Care and Services)**

**CALL**        1-800-282-5366 (Calls to this number are free).  
7 days per week, 8am-8pm.  
1-800-932-2159 for expedited requests.

**TTY/TDD**    1-888-760-4748 (This number requires special telephone equipment; calls to this  
number are free).

**FAX**         1-866-604-7091 or 1-909-476-5216  
1-860-975-9631 for expedited requests

**WRITE**        Aetna Medicare Grievance and Appeal Unit  
P.O. Box 14067  
Lexington, KY 40512

**Appeals (about your Medical Care and Services)**

- CALL** 1-800-932-2159 for expedited appeals. (Calls to this number are free).
- TTY/TDD** 1-888-760-4748 (This number requires special telephone equipment; calls to this number are free).
- FAX** 1-866-604-7092  
1-860-975-9631 for expedited requests
- WRITE** Aetna Medicare Grievance and Appeal Unit  
P.O. Box 14067  
Lexington, KY 40512

**Part D Coverage Determinations (about your Part D Prescription Drugs)**

- CALL** 1-888-972-3862 (Calls to this number are free).  
Monday through Friday, 8am-8pm.
- TTY/TDD** 1-888-760-4748 (This number requires special telephone equipment; calls to this number are free).
- FAX** 1-800-408-2386
- WRITE** Aetna Pharmacy Management Precertification Unit  
300 Highway 169 South  
Suite 500  
Minneapolis, MN 55426

**Part D Reimbursement Requests (about your Part D prescription drugs)**

- CALL** 1-888-972-3862 (Calls to this number are free).
- TTY/TDD** 1-888-760-4748 (This number requires special telephone equipment; calls to this number are free).
- FAX** 1-860-262-9437
- WRITE** Aetna Medicare Prescription Drug Claim Processing Unit  
P.O. Box 14023  
Lexington, KY 40512

### **Part D Grievances (about your Part D Prescription Drugs)**

- CALL** 1-877-238-6211 (Calls to this number are free).  
7 days per week, 8am-8pm.  
1-877-235-3755 for expedited requests.
- TTY/TDD** 1-888-760-4748 (This number requires special telephone equipment; calls to this number are free.)
- WRITE** Aetna Medicare Grievance and Appeal Unit  
P.O. Box 14579  
Lexington, KY 40512

### **Part D Appeals (about your Part D Prescription Drugs)**

- CALL** 1-877-235-3755 for expedited appeals.
- TTY/TDD** 1-888-760-4748 this number requires special telephone equipment.  
Calls to this number are free.
- FAX** 1-866-604-7092
- WRITE** Aetna Medicare Grievance and Appeal Unit  
P.O. Box 14579  
Lexington, KY 40512

### **Other important contacts**

Below is a list of other important contacts. For the most up-to-date contact information, check your Medicare & You Handbook, visit [www.medicare.gov](http://www.medicare.gov) and choose “Find Helpful Phone Numbers and Resources,” or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

### **State Health Insurance Assistance Program (SHIP)**

A SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

Please refer to the SHIP listing at the back of this document. You may also find the website for your local SHIP at [www.medicare.gov](http://www.medicare.gov) under “Search Tools” by selecting “Helpful Phone Numbers and Websites.”

### **Quality Improvement Organization**

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. Please refer to the QIO chart at the end of this document for your specific state information.

### **How to contact the Medicare program**

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

Visit [www.medicare.gov](http://www.medicare.gov) for information. This is the official government website for Medicare. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under “Search Tools” for Medicare contacts in your state. Select “Helpful Phone Numbers and Websites.” 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.

### **Medicaid**

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the applicable state Medicaid agencies/state departments of health and social services. You may also contact Member Services for additional information.

### **Social Security**

Social Security programs include retirement benefits, disability benefits, family benefits, survivors’ benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit [www.ssa.gov](http://www.ssa.gov) on the Web.

**State-specific name of State Pharmacy Assistance Program (SPAP)**

SPAPs are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact the SPAP in your state. Please refer to the chart at the end of this of this document for your state specific information, if available.

**Railroad Retirement Board**

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit [www.rrb.gov](http://www.rrb.gov) on the Web.

**Important Contact Information**

Alabama	<p>State Health Insurance Assistance Program: 1-877-2243 TTY/TDD: 1-334-242-0995</p> <p>Quality Improvement Organization: AQAF Two Perimeter Park South Suite 200 W Birmingham, AL 35243 1-205-970-1600 1-800-760-4550</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 61 Forsyth Street, SW – Suite 3B70 Atlanta, Georgia 30323 1-404-562-7886 TTY/TDD: 1-404-331-2867</p> <p>Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103-5624 1-334-242-5000</p>
Alaska	<p>State Health Insurance Assistance Program: 1-800-478-6065 (in state calls only) TTY/TDD: 1-907-269-3691</p> <p>Quality Improvement Organization: Mountain Pacific Quality Health Foundation 4241 B Street, Suite 303 Anchorage, AK 99503 1-907-561-3202</p>

	<p>1-877-561-3202</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 2201 Sixth Avenue- Mail Stop RX-11 Seattle, WA 98121 1-206-615-2290 TTY/TDD: 206-615-2296</p> <p>Division of Public Assistance P.O. Box 110640 Juneau, AK 99811-0640 1-907-465-3347</p>
Arizona	<p>State Health Insurance Assistance Program: 1-800-432-4040 TTY/TDD: 1-602-542-6366</p> <p>Quality Improvement Organization: Health Services Advisory Group, Inc.(HSAG) 1600 East Northern Avenue, Suite 100 Phoenix, Arizona 85020-3933 Phone: 602-264-6382 Phone: 1-800-359-9909</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 50 United Nations Plaza- Room 322 San Francisco, CA 94102 1-415-437-8310 TTY/TDD: 415-437-8311 Healthcare Cost Containment of Arizona 801 E. Jefferson Street Phoenix, AZ 85034 1-800-962-6690</p>
Arkansas	<p>State Health Insurance Assistance Program 1-800-224-6330</p> <p>Quality Improvement Organization: Arkansas Foundation for Medical Care 401 West Capitol Little Rock, AR 72201 1-800-272-5528</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 1301 Young Street- Suite 1169</p>

	<p>Dallas, TX 75202  1-214-767-4056  TTY/TDD: 214-767-8940</p> <p>Arkansas DHHS - Division of County Operations  Office of Program Planning and Development  P. O. Box 1437 - MS 333  Little Rock, AR 72203  1-501-682-8256</p>
California	<p>State Health Insurance Assistance Program:  1-800-434-0222 (in-state calls only)  TTY/TDD: 1-800-735-2929</p> <p>Quality Improvement Organization:  Health Services Advisory Group  700 N. Brand Blvd. Suite 370  Glendale, CA 91203  1-800-841-1602</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  50 United Nations Plaza- Room 322  San Francisco, CA 94102  1-415-437-8310  TTY/TDD: 415-437-8311</p> <p>California Department of Health Services  P.O. Box 997413  Sacramento, CA 95899-7413  1-916-440-7800</p>
Colorado	<p>State Health Insurance Assistance Program:  1-888-696-7213  1-800-544-9181 (in state calls only)  TTY/TDD: 1-303-894-7880</p> <p>Quality Improvement Organization:  Colorado Foundation for Medical Care  23 Inverness Way East, Suite 100  Englewood, CO 80112-5708  1-303-695-3333  1-800-727-7086</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  1961 Stout Street- Room 1426</p>

	<p>Denver, CO 80294  1-303-844-2024  TTY/TDD: 303-844-3439</p> <p>Department of Health Care Policy and Financing  1570 Grant Street  Denver, Colorado 80203  800-237-0044</p>
Connecticut	<p>State Health Insurance Assistance Program:  1-800-994-9422 (in state calls only)  TTY/TTD: 1-800-842-5424</p> <p>Quality Improvement Organization:  Qualidigm  100 Roscommon Drive  Middletown, CT 06457  1-800-553-7590</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  JFK Federal Building- Room 1875  Boston, MA 02203  617-565-1340  TTY/TDD: 617-565-1343</p> <p>State Pharmacy Assistance Program:  ConnPace  800-423-5026  800-994-9422</p> <p>Department of Social Services of Connecticut  25 Sigourney Street  Hartford, CT 06106-5033  Local: 1-860-424-4908  Toll-Free: In-State Calls Only 1-800-842-1508</p>
Delaware	<p>State Health Insurance Assistance Program:  1-800-336-9500 (in state calls only)</p> <p>Quality Improvement Organization:  Quality Insights of Delaware  Baynard Building, Suite 100  3411 Silverside Rd.  Wilmington, DE 19810-4812  Phone: 302-478-3600  Phone: 1-866-475-9669</p>

	<p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  150 S. Independence Mall West- Suite 372  Philadelphia, PA 19106-3499  215-861-4441  TTY/TDD: 215-861-4440</p> <p>State Pharmacy Assistance Program:  Delaware Prescription Assistance Program (DPAP)  800-996-9969 ext 17</p> <p>Delaware Health and Social Services  1901 N. DuPont Highway  P.O. Box 906, Lewis Bldg.  New Castle, DE 19720  Local: 1-302-255-9040  Toll-Free: In-State Calls Only 1-800-372-2022</p>
Florida	<p>State Health Insurance Assistance Program:  1-800-963-5337  TTY/TTD: 1-800-955-8770</p> <p>Quality Improvement Organization:  Florida Medical Quality Assurance, Inc.(FMQAI)  4350 West Cypress Street, Suite 900  Tampa, Florida 33607-4181  Phone: 813-354-9111  Phone: 1-800-564-7490</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  61 Forsyth Street, S.W.- Suite 3B70  Atlanta, GA 30323  404-562-7886  TTY/TDD: 404-331-2867</p> <p>Agency for Health Care Administration of Florida  P.O. Box 13000  Tallahassee, FL 32317-3000  Toll-Free: 1-888-419-3456</p>
Georgia	<p>State Health Insurance Assistance Program:  1-800-669-8387</p> <p>Quality Improvement Organization:  Georgia Medical Care Foundation (GMCF)</p>

	<p>1455 Lincoln Pkwy, Suite 800 Atlanta, GA 30346 Phone: 1-800-982-0411 Phone; 404-982-0411</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 61 Forsyth Street, S.W.- Suite 3B70 Atlanta, GA 30323 404-562-7886 TTY/TDD: 404-331-2867</p> <p>Georgia Department of Community Health 2 Peachtree Street, NW Atlanta, GA 30303 Local: 1-770-570-3300 Toll-Free: 1-866-322-4260</p>
Hawaii	<p>State Health Insurance Assistance Program: 1-888-875-9229</p> <p>Quality Improvement Organization: Mountain-Pacific Quality Health Foundation 1360 S. Beretania, Suite 501 Honolulu, HI 96814 1-808-545-2550 1-800-524-6550</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 50 United Nations Plaza- Room 322 San Francisco, CA 94102 415-437-8310 TTY/TDD: 415-437-8311</p> <p>State Pharmacy Assistance Program P.O. Box 700220 Kapolei, HI 96709 1-808-692-7999</p> <p>Department of Human Services of Hawaii P.O. Box 339 Honolulu, HI 96809 Local: 1-808-587-3521</p>
Idaho	State Health Insurance Assistance Program:

	<p>1-800-247-4422 (in state calls only) TTY/TDD: 1-800-377-3529</p> <p>Quality Improvement Organization: Qualis Health 720 Park Blvd., Ste. 120 Boise, ID 83712 1-208-343-4617 1-877-575-8309</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 2201 Sixth Avenue- Mail Stop RX-11 Seattle, WA 98121 206-615-2290 TTY/TDD: 206-615-2296</p> <p>Idaho Department of Health and Welfare 450 West State Street Boise, ID 83720-0036 Local: 1-208-334-5500 Toll-Free: 1-800-685-3757</p>
Illinois	<p>State Health Insurance Assistance Program: 1-800-548-9034 (in state calls only) TTY/TDD: 1-217-524-4872</p> <p>Quality Improvement Organization: Illinois Foundation for Quality Health Care (IFQHC) 2625 Butterfield Road, Suite 102E Oak Brook, IL 60523-1234 Phone: 630-571-5540 Phone: 1-800-386-6431</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 233 N. Michigan Avenue- Suite 240 Chicago, IL 60601 312-886-2359 TTY/TDD: 312-353-5693</p> <p>State Pharmacy Assistance Program: Illinois SeniorCare or Circuit Breaker and Pharmaceutical Assistance Programs 800-226-0768 800-624-2459</p>

	<p>Department of Public Aid of Illinois  201 South Grand Avenue, East  Springfield, IL 62763  Local: 1-217-782-1200  Toll-Free: 1-800-226-0768</p>
Indiana	<p>State Health Insurance Assistance Program:  1-800-452-4800</p> <p>Quality Improvement Organization:  Health Care Excel  2629 Waterfront Parkway East Drive  Indianapolis, IN 46214  1-800-288-1499</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  233 N. Michigan Avenue- Suite 240  Chicago, IL 60601  312-886-2359  TTY/TDD: 312-353-5693</p> <p>State Pharmacy Assistance Program:  Hoosier Rx  866-267-4679</p> <p>Family and Social Services Administration of Indiana  402 W. Washington Street  P.O. Box 7083  Indianapolis, IN 46207-7083  Local: 1-317-233-4455  Toll-Free: 1-800-889-9949</p>
Iowa	<p>State Health Insurance Assistance Program:  1-800-351-4664  TTY/TDD: 1-800-735-2942</p> <p>Quality Improvement Organization:  Iowa Foundation for Medical Care  6000 Westown Parkway  West Des Moines, Iowa 50266-7771  1-515-223-2900  1-800-752-7014</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  601 East 12<sup>th</sup> Street- Suite 248  Kansas City, MO 64106</p>

	<p>816-426-7278 TTY/TDD: 816-426-7065</p> <p>Department of Human Services of Iowa Hoover State Office Building 5th Floor Des Moines, IA 50319-0114 Local: 1-515-327-5121 Toll-Free: 1-800-338-8366</p>
Kansas	<p>State Health Insurance Assistance Program: 1-800-860-5260</p> <p>Quality Improvement Organization: Kansas Foundation for Medical Care 2947 SW Wanamaker Drive Topeka, KS 66614-4193 1-800-432-0407 1-785-273-2552</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 601 East 12<sup>th</sup> Street- Suite 248 Kansas City, MO 64106 816-426-7278 TTY/TDD: 816-426-7065</p> <p>Department of Social and Rehabilitation Services of Kansas 915 SW Harrison Street Topeka, KS 66612 Local: 1-785-274-4200 Toll-Free: 1-800-766-9012</p>
Kentucky	<p>State Health Insurance Assistance Program: 1-877-293-7447 TTY/TDD: 1-888-642-1137</p> <p>Quality Improvement Organization: Health Care Excel 1951 Bishop Lane, Suite 300 Louisville, KY 40218 1-502-454-5112</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 61 Forsyth Street, S.W.- Suite 3B70 Atlanta, GA 30323 404-562-7886</p>

	<p>TTY/TDD: 404-331-2867</p> <p>Cabinet for Health Services of Kentucky  P.O. Box 2110  Frankfort, KY 40602-2110  Local: 1-502-564-4321  Toll-Free: 1-800-635-2570</p>
Louisiana	<p>State Health Insurance Assistance Program:  1-800-259-5301 (in state calls only)</p> <p>Quality Improvement Organization:  Louisiana Health Care Review  8591 United Plaza Boulevard, Suite 270  Baton Rouge, Louisiana 70809  1-225-926-6353</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  1301 Young Street- Suite 1169  Dallas, TX 75202  214-767-4056  TTY/TDD: 214-767-8940</p> <p>Louisiana Department of Health and Hospital  P.O. Box 91278  Baton Rouge, LA 70821-9278  Local: 1-225-342-9500</p>
Maine	<p>State Health Insurance Assistance Program:  1-800-750-5353 (in state calls only)</p> <p>Quality Improvement Organization:  Northeast Health Care Quality Foundation  15 Old Rollinsford Road, Suite 302  Dover, NH 03820-2830  1-800-772-0151</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  JFK Federal Building- Room 1875  Boston, MA 02203  617-565-1340  TTY/TDD: 617-565-1343</p> <p>State Pharmacy Assistance Program:  Maine Rx Plus or Maine Low Cost Drugs for the Elderly and Disabled Program</p>

	<p>866-796-2463 800-262-2232</p> <p>Maine Department of Health and Human Services 442 Civic Center Drive 11 State House Station Augusta, ME 04333-0011 Local: 1-207-624-7539 (Eligibility) Toll-Free: 1-800-977-6740 (option 2)</p>
Maryland	<p>State Health Insurance Assistance Program: 1-800-243-3425 (in state calls only) TTY/TTD: 1-410-767-1083</p> <p>Quality Improvement Organization: Delmarva Foundation for Medical Care, Inc (Delmarva) 9240 Centreville Road Easton, MD 21601 800-492-5811</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 150 S. Independence Mall West- Suite 372 Philadelphia, PA 19106-3499 215-861-4441 TTY/TDD: 215-861-4440</p> <p>State Pharmacy Assistance Program: Maryland Pharmacy Assistance Program or Senior Short Term Prescription Drug Plan 800-226-2142 800-972-4612</p> <p>Department of Health and Mental Hygiene P.O. Box 17259 Baltimore, MD 21203-7259 Local: 1-410-767-5800 Toll-Free: 1-800-492-5231</p>
Massachusetts	<p>State Health Insurance Assistance Program 1-800-243-4636 TTY/TDD: 1-877-610-0241</p> <p>Quality Improvement Organization: MassPRO 245 Winter Street Waltham, MA 02451-1231 1-781-890-0011</p>

	<p>1-800-252-5533</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services JFK Federal Building- Room 1875 Boston, MA 02203 617-565-1340 TTY/TDD: 617-565-1343</p> <p>State Pharmacy Assistance Program: Prescription Advantage 800-243-4636</p> <p>Office of Health and Human Services of Massachusetts 600 Washington Street Boston, MA 02111 Local: 1-617-628-4141 (for provider only) Toll-Free: 1-800-841-2900</p>
Michigan	<p>State Health Insurance Assistance Program 1-800-803-7174</p> <p>Quality Improvement Organization: MPRO 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 1-248-465-7300 1-248-465-7457</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 233 N. Michigan Avenue- Suite 240 Chicago, IL 60601 312-886-2359 TTY/TDD: 312-353-5693</p> <p>State Pharmacy Assistance Program: Michigan's Elder Prescription Insurance Coverage 866-747-5844</p> <p>Michigan Department Community Health Sixth Floor, Lewis Cass Building 320 South Walnut Street Lansing, MI 48913 Local: 1-517-373-3740</p>
Minnesota	<p>State Health Insurance Assistance Program: 1-800-333-2433</p>

	<p>TTY/TDD: 1-800-627-3529</p> <p>Quality Improvement Organization: Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525 1- 952.854.3306 1-877-STRATIS</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 233 N. Michigan Avenue- Suite 240 Chicago, IL 60601 312-886-2359 TTY/TDD: 312-353-5693</p> <p>State Pharmacy Assistance Program: Minnesota's Prescription Drug Program 800-333-2433</p> <p>Department of Human Services of Minnesota 444 Lafayette Road North St. Paul, MN 55155 Local: 1-651-297-3933 Toll-Free: 1-800-333-2433</p>
Mississippi	<p>State Health Insurance Assistance Program: 1-800-948-3090 TTY/TDD: 1-800-676-4154</p> <p>Quality Improvement Organization: Information and Quality Healthcare Renaissance Place - Suite 504 385B Highland Colony Parkway Ridgeland, MS 39157-6035 1-601-957-1575</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 61 Forsyth Street, S.W.- Suite 3B70 Atlanta, GA 30323 404-562-7886 TTY/TDD: 404-331-2867</p> <p>Office of the Governor of Mississippi</p>

	<p>239 North Lamar Street, Suite 801  Robert E. Lee Bldg.  Jackson, MS 39201-1399  Local: 1-601-359-6050  Toll-Free: 1-800-421-2408</p>
Missouri	<p>State Health Insurance Assistance Program:  1-800-390-3330</p> <p>Quality Improvement Organization:  Primaris  200 North Keene Street  Columbia, Missouri 65201  1-800-390-3330</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  601 East 12<sup>th</sup> Street- Suite 248  Kansas City, MO 64106  816-426-7278  TTY/TDD: 816-426-7065</p> <p>State Pharmacy Assistance Program:  Missouri Senior Rx Program  800-375-1406</p> <p>Department of Social Services of Missouri  221 West High Street  P.O. Box 1527  Jefferson City, MO 65102-1527  Local: 1-573-751-4815  Toll-Free: In-State Calls Only 1-800-392-2161</p>
Montana	<p>State Health Insurance Assistance Program:  1-800-551-3191 (in state calls only)  TTY/TDD: 1-800-253-4091</p> <p>Quality Improvement Organization:  Mountain-Pacific Quality Health Foundation  3404 Cooney Drive  Helena, MT 59602  1-406-443-4020  1-800-497-8232</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  1961 Stout Street- Room 1426  Denver, CO 80294</p>

	<p>303-844-2024 TTY/TDD: 303-844-3439</p> <p>Montana Big Sky Rx Program P.O. Box 202915 Helena, MT 59620 1-866-369-1233</p> <p>Montana Department of Public Health &amp; Human Services-Division of Child and Adult Health Resources 1400 Broadway, Cogswell Building P.O. Box 8005 Helena, MT 59604-8005 Local: 1-406-444-4540 Toll-Free: In-State Calls Only 1-800-362-8312</p>
Nebraska	<p>State Health Insurance Assistance Program 1-800-234-7119 TTY/TDD: 1-800-833-7352</p> <p>Quality Improvement Organization: CIMRO of Nebraska 1230 O Street, Suite 120 Lincoln, Nebraska 68508 1-402-476-1399 1- 800-458-4262</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 601 East 12<sup>th</sup> Street- Suite 248 Kansas City, MO 64106 816-426-7278 TTY/TDD: 816-426-7065</p> <p>Nebraska Department of Health and Human Services System P.O. Box 95044 Lincoln, NE 68509-5044 Local: 1-402-471-3121 Toll-Free: 1-800-430-3244</p>
Nevada	<p>State Health Insurance Assistance Program: 1-800-307-4444</p> <p>Quality Improvement Organization: HealthInsight 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118</p>

	<p>1-702-385-9933</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 50 United Nations Plaza- Room 322 San Francisco, CA 94102 415-437-8310 TTY/TDD: 415-437-8311</p> <p>State Pharmacy Assistance Program: Senior Rx 866-303-6323</p> <p>Nevada Department of Human Resources, Aging Division 1100 East William Street Suite 101 Carson City, NV 89701 Local: 1-775-684-7200</p>
New Hampshire	<p>State Health Insurance Assistance Program 1-800-852-3388 (in state calls only) TTY/TDD: 1-603-225-9000</p> <p>Quality Improvement Organization: Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830 1-800-772-0151 1-603-749-1641</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services JFK Federal Building- Room 1875 Boston, MA 02203 617-565-1340 TTY/TDD: 617-565-1343</p> <p>New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857 Local: 1-603-271-4238 Toll-Free: 1-800-852-3345</p>
New Jersey	<p>State Health Insurance Assistance Program 1-800-792-8820 (in state calls only) 1-877-222-3737 (out of state toll free) TTY/TDD: 1-900-852-7899</p>

	<p>Quality Improvement Organization: Healthcare Quality Strategies, Inc. 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-4026 1- 732-238-5570</p> <p>Quality Improvement Organization: Peer Review Organization of New Jersey, Inc. (PRO NJ) 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816 732-238-5570 (In-State Calls Only)</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 26 Federal Plaza- Suite 3313 New York, NY 10278 212-264-3313 TTY/TDD: 212-264-2355</p> <p>State Pharmacy Assistance Program: Pharmaceutical Assistance to the Aged &amp; Disabled or Senior Gold Prescription Discount 800-792-9745</p> <p>Department of Human Services of New Jersey Quakerbridge Plaza, Building 7 P.O. Box 712 Trenton, NJ 08625-0712 Local: 1-609-588-2600 Toll-Free: In-State Calls Only 1-800-356-1561</p>
New Mexico	<p>State Health Insurance Assistance Program: 1-800-432-2080 (in state calls only)</p> <p>Quality Improvement Organization: New Mexico Medical Review Association 5801 Osuna Road NE, Suite 100A Albuquerque, NM 87109 1-505-998-9898</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 1301 Young Street- Suite 1169 Dallas, TX 75202 214-767-4056 TTY/TDD: 214-767-8940</p>

	<p>Department of Human Services of New Mexico  P.O. Box 2348  Sante Fe, NM 87504-2348  Local: 1-505-827-3100  Toll-Free: 1-888-997-2583</p>
New York	<p>State Health Insurance Assistance Program:  1-800-333-4114</p> <p>Quality Improvement Organization:  IPRO  1979 Marcus Avenue  Lake Success, NY 11042-1002  1-800-446-2447  1-516-326-7767</p> <p>Quality Improvement Organization:  Island Peer Review Organization (IPRO)  1979 Marcus Avenue  Suite 105  Lake Success, NY 11042-1002  800-331-7767</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  26 Federal Plaza- Suite 3313  New York, NY 10278  212-264-3313  TTY/TDD: 212-264-2355</p> <p>State Pharmacy Assistance Program:  Elderly Pharmaceutical Insurance Coverage (EPIC) Program  800-332-3742</p> <p>New York State Department of Health  Office of Medicaid Management  Governor Nelson A. Rockefeller Empire State Plaza, Corning Tower  Building  Albany, NY 12237  Local: 1-518-486-9057  Toll-Free: 1-800-541-2831</p>
North Carolina	<p>State Health Insurance Assistance Program:  1-800-443-9354 (in state calls only)  TTY/TDD: 1-800-735-2962</p> <p>Quality Improvement Organization:</p>

	<p>The Carolinas Center for Medical Excellence  100 Regency Forest Drive, Suite 200  Cary, NC 27518-8598  1-919-380-9860  1-800-682-2650</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  61 Forsyth Street, S.W. - Suite 3B70  Atlanta, GA 30323  404-562-7886  TTY/TDD: 404-331-2867</p> <p>State Pharmacy Assistance Program:  North Carolina Senior Care  866-226-1388</p> <p>North Carolina Department of Health and Human Services  Division of Medical Assistance  2501 Mail Service Center  Raleigh, NC 27699-2501  Local: 1-919-855-4100  Toll-Free: In-State Calls Only 1-800-662-7030</p>
North Dakota	<p>State Health Insurance Assistance Program:  1-800-247-0560  TTY/TDD: 1-800-366-6888</p> <p>Quality Improvement Organization:  North Dakota Health Care Review  800 31st Ave SW.  Minot, North Dakota, 58701  1-800-472-2902  1-888-472-2902</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  1961 Stout Street- Room 1426  Denver, CO 80294  303-844-2024  TTY/TDD: 303-844-3439</p> <p>Dept of Human Services of North Dakota - Medical Services  600 E. Boulevard Avenue  Bismarck, ND 58505-0250  Local: 1-701-328-2321  Toll-Free: 1-800-755-2604</p>

Ohio	<p>State Health Insurance Assistance Program: 1-800-686-1578 TTY/TDD: 1-614-644-3745</p> <p>Quality Improvement Organization: Ohio KePRO Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 Phone: 216-447-9604 Phone: 1-800-589-7337</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 233 N. Michigan Avenue- Suite 240 Chicago, IL 60601 312-886-2359 TTY/TDD: 312-353-5693</p> <p>Department of Job and Family Services of Ohio - Ohio Health Plans 30 East Broad Street 31st Floor Columbus, OH 43215-3414 Local: 1-614-728-3288 Toll-Free: 1-800-324-8680</p>
Oklahoma	<p>State Health Insurance Assistance Program: 1-800-762-2828 (in state calls only)</p> <p>Quality Improvement Organization: Oklahoma Foundation for Medical Quality 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134 1-800-522-3414</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 1301 Young Street- Suite 1169 Dallas, TX 75202 214-767-4056 TTY/TDD: 214-767-8940 Health Care Authority of Oklahoma 4545 N. Lincoln Boulevard Suite 124 Oklahoma City, OK 73105 Local: 1-405-522-7171 (also (405) 522-7300) Toll-Free: 1-800-522-0310</p>

Oregon	<p>State Health Insurance Assistance Program: 1-800-722-4134 (in state calls only) TTY/TDD: 1-503-947-7280</p> <p>Quality Improvement Organization: Acumentra Health 2020 SW Fourth Avenue, Suite 520 Portland, Oregon 97201-4960 1-503-279-0100</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 2201 Sixth Avenue- Mail Stop RX-11 Seattle, WA 98121 206-615-2290 TTY/TDD: 206-615-2296</p> <p>Oregon Department of Human Services 500 Summer Street, NE 3rd Floor Salem, OR 94310-1014 Local: 1-503-945-5772 Toll-Free: 1-800-527-5772</p>
Pennsylvania	<p>State Health Insurance Assistance Program: 1-800-783-7067</p> <p>Quality Improvement Organization: Quality Insights of Pennsylvania 2601 Market Place Street Harrisburg, PA 17110 877-346-6180</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 150 S. Independence Mall West- Suite 372 Philadelphia, PA 19106-3499 215-861-4441 TTY/TDD: 215-861-4440</p> <p>State Pharmacy Assistance Program: PACE-Pharmaceutical Assistance Contract for the Elderly or PACENET 800-225-7223</p> <p>Department of Public Welfare of Pennsylvania Health and Welfare Building, Rm 515</p>

	<p>P.O. Box 2675  Harrisburg, PA 17105  Local: 1-717-787-1870  Toll-Free: 1-800-692-7462</p>
Puerto Rico	<p>State Health Insurance Assistance Program:  1-877-725-4300</p> <p>Quality Improvement Organization:  Qipro  Mercantil Plaza Building  2 Avenue Ponce De Leon, Suite 709  San Juan, PR 00918-1696  1-787-641-1240</p> <p>State Pharmacy Assistance Program  1-888-477-2669  State Medical Assistance Office  1-877-725-4300</p>
Rhode Island	<p>State Health Insurance Assistance Program:  1-401-462-0508</p> <p>Quality Improvement Organization:  Quality Partners of Rhode Island  235 Promenade Street  Suite 500, Box 18  Providence, RI 02908  1- 401-528-3200</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  JFK Federal Building- Room 1875  Boston, MA 02203  617-565-1340  TTY/TDD: 617-565-1343</p> <p>State Pharmacy Assistance Program:  R.I. Pharmaceutical Assistance Program to the Elderly (RIPAE)  401-462-3000</p> <p>Department of Human Services of Rhode Island  Louis Pasteur Building  600 New London Avenue  Cranston, RI 02921  Local: 1-401-462-5300  Toll-Free: 1-800-984-8989</p>

<p>South Carolina</p>	<p>State Health Insurance Assistance Program: 1-800-868-9095</p> <p>Quality Improvement Organization: The Carolinas Center for Medical Excellence 246 Stoneridge Drive, Suite 200 Columbia, SC 29210 1-803-251-2215 1-800-922-3089</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 61 Forsyth Street, S.W.- Suite 3B70 Atlanta, GA 30323 404-562-7886 TTY/TDD: 404-331-2867</p> <p>South Carolina Gap Assistance Rx Program for Seniors P.O. Box 8206 Columbia, SC 29202 1-888-549-0820</p> <p>South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 Local: 1-803-898-2500</p>
<p>South Dakota</p>	<p>State Health Insurance Assistance Program: 1-800-536-8197 TTY/TDD: 1-800-642-6410</p> <p>Quality Improvement Organization: South Dakota Foundation for Medical Care 1323 S. Minnesota Ave. Sioux Falls, SD 57105 1-605-336-3505 1-800-MEDICARE</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 1961 Stout Street- Room 1426 Denver, CO 80294 303-844-2024 TTY/TDD: 303-844-3439</p> <p>Department of Social Services of South Dakota 700 Governors Drive</p>

	<p>Richard F Kneip Bldg,  Pierre, SD 57501  Local: 1-605-773-3495  Toll-Free: 1-800-452-7691 (Providers Only)</p>
Tennessee	<p>State Health Insurance Assistance Program:  1-877-801-0044  TTY/TDD: 1-800-848-0299</p> <p>Quality Improvement Organization:  QS Source  3175 Lenox Park Blvd., Suite 309  Memphis, TN 38115  1-800-528-2655 (For In-patient hospitalization)  1-800-261-1437 (For Skilled Nursing Facility, Home Health,  Comprehensive Outpatient Rehabilitation Facility)</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  61 Forsyth Street, S.W.- Suite 3B70  Atlanta, GA 30323  404-562-7886  TTY/TDD: 404-331-2867</p> <p>Bureau of TennCare  310 Great Circle Rd.  Nashville, TN 37243  Toll-Free: 1-866-311-4287</p>
Texas	<p>State Health Insurance Assistance Program:  1-800-252-9240  TTY/TDD: 1-800-735-2989</p> <p>Quality Improvement Organization:  Texas Medical Foundation  Barton Oaks Plaza Two, Suite 200  901 Mopac Expressway South  Austin, Texas 78746-5799  Phone: 1-800-725-9216  Local Phone: 512-329-6610</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  1301 Young Street- Suite 1169  Dallas, TX 75202  214-767-4056  TTY/TDD: 214-767-8940</p>

	<p>State Pharmacy Assistance Program: Kidney Health Care Program 800-222-3986</p> <p>Health and Human Services Commission of Texas 4900 N. Lamar Boulevard 4th Floor Austin, TX 78701 Local: 1-512-424-6500 Toll-Free: 1-888-834-7406</p>
Utah	<p>State Health Insurance Assistance Program: 1-800-541-7735 (in state calls only)</p> <p>Quality Improvement Organization: HealthInsight 348 East 4500 South, Suite 300 Salt Lake City, Utah 84107 1- 801-892-0155</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 1961 Stout Street- Room 1426 Denver, CO 80294 303-844-2024 TTY/TDD: 303-844-3439</p> <p>Utah Department of Health 288 North 1460 West P.O. Box 143101 Salt Lake City, UT 84114-3101 Local: 1-801-538-6155 Toll-Free: 1-800-662-9651</p>
Vermont	<p>State Health Insurance Assistance Program: 1-800-642-5119 (in state calls only)</p> <p>Quality Improvement Organization: Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830 1-800-772-0151 1-603-749-1641</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services JFK Federal Building- Room 1875</p>

	<p>Boston, MA 02203 617-565-1340 TTY/TDD: 617-565-1343</p> <p>State Pharmacy Assistance Program: VHAP (Vermont Health Access Plan) Pharmacy Benefit or VSCRIPT 800-250-8427</p> <p>Agency of Human Services of Vermont 103 South Main Street Waterbury, VT 05676-1201 Local: 1-802-879-5900 Toll-Free: In-State Calls Only 1-800-250-8427</p>
Virginia	<p>State Health Insurance Assistance Program: 1-800-552-3402</p> <p>Quality Improvement Organization: Virginia Health Quality Center 4510 Cox Road Suite 400 Glen Allen, VA 23060 Phone: 1-800-545-3814 Phone: 804-289-5320</p> <p>Office for Civil Rights U.S. Department of Health &amp; Human Services 150 S. Independence Mall West- Suite 372 Philadelphia, PA 19106-3499 215-861-4441 TTY/TDD: 215-861-4440</p> <p>Department of Medical Assistance Services 600 East Broad Street Suite 1300 Richmond, VA 23219 Local: 1-804-786-6273 Toll-Free: In-State Calls Only 1-800-552-8627</p>
Washington	<p>State Health Insurance Assistance Program: 1-800-562-6900 TTY/TDD: 1-360-664-3154</p> <p>Quality Improvement Organization: Qualis Health 10700 Meridian N., Ste. 100 Seattle, WA 98133 1-206-364-9700</p>

	<p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  2201 Sixth Avenue- Mail Stop RX-11  Seattle, WA 98121  206-615-2290  TTY/TDD: 206-615-2296</p> <p>Department of Social and Health Services of Washington  P.O. Box 45505  Olympia, WA 98504-5505  Local: 1-800-562-6188  Toll-Free: In-State Calls Only 1-800-562-3022</p>
Washington, D.C.	<p>State Health Insurance Assistance Program:  1-202-739-0668  TTY/TDD: 1-202-973-1079</p> <p>Quality Improvement Organization:  Delmarva Foundation for Medical Care, Inc. (Delmarva)  District of Columbia Office (DFDC)  1620 L Street, NW, Suite 1275  Washington, DC 20036  1-202-293-9650  1-800-999-3362</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  150 S. Independence Mall West- Suite 372  Philadelphia, PA 19106-3499  215-861-4441  TTY/TDD: 215-861-4440</p> <p>DC Healthy Family  825 North Capitol Street, NE  5th Floor  Washington, DC 20002  Local: 1-202-442-5999</p>
West Virginia	<p>State Health Insurance Assistance Program:  1-877-987-4463</p> <p>Quality Improvement Organization:  WVMI Quality Insights  3001 Chesterfield Place  Charleston, WV 25304  1-304-346-9864  1-800-642-8686</p>

	<p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  150 S. Independence Mall West- Suite 372  Philadelphia, PA 19106-3499  215-861-4441  TTY/TDD: 215-861-4440</p> <p>West Virginia Department of Health &amp; Human Resources  350 Capitol Street  Room 251  Charleston, WV 25301-3709  Local: 1-304-558-1700</p>
Wisconsin	<p>State Health Insurance Assistance Program:  1-800-242-1060</p> <p>Quality Improvement Organization:  MetaStar, Inc.  2909 Landmark Place  Madison, WI 53713  1-608-274-1940  1-800-362-2320</p> <p>Office for Civil Rights  U.S. Department of Health &amp; Human Services  233 N. Michigan Avenue- Suite 240  Chicago, IL 60601  312-886-2359  TTY/TDD: 312-353-5693</p> <p>State Pharmacy Assistance Program:  Senior Care  800-657-2038</p> <p>Wisconsin Department of Health and Family Services  1 West Wilson Street  P.O. Box 309  Madison, WI 53701-0309  Local: 1-608-221-5720  Toll-Free: 1-800-362-3002</p>
Wyoming	<p>State Health Insurance Assistance Program  1-800-856-4398</p> <p>Quality Improvement Organization:  2206 Dell Range Blvd., Suite G</p>

Cheyenne, WY 82009  
1-307-637-8162  
1-877-810-6248

Office for Civil Rights  
U.S. Department of Health & Human Services  
1961 Stout Street- Room 1426  
Denver, CO 80294  
303-844-2024  
TTY/TDD: 303-844-3439

State Pharmacy Assistance Program:  
Prescription Drug Assistance Program  
1-307-777-6032

Wyoming Department of Health  
147 Hathaway Building  
Cheyenne, WY 82002  
1-307-777-7531

**AETNA LIFE INSURANCE COMPANY**

**GROUP PRESCRIPTION DRUG  
SCHEDULE OF COPAYMENTS/COINSURANCE**

**Contract Holder Name:** The City Of Seattle

**Contract Holder Group Agreement Effective Date:** January 1, 2010

**Contract Holder Number:** 395280

**Deductible Amount** **None**

**Formulary Type:** **Closed or Standard Formulary**

***Initial Coverage Limit***

**Amount you pay, up to \$2,830 in total covered prescription drug expenses:**

<b>Prescription Drug/Medicine Quantity</b>	<b>Generic Prescription drugs</b>	<b>Preferred Brand Prescription drugs</b>	<b>Non-preferred Brand Prescription drugs</b>
1 month supply (31 days) of covered prescription drugs at a network retail pharmacy	<b>\$5</b>	<b>\$20</b>	<b>\$40</b>
3 month (90 day) supply of covered prescription drugs at a network retail pharmacy; or through a non-preferred mail order pharmacy	<b>\$15</b>	<b>\$60</b>	<b>\$120</b>
90 day supply of covered prescription drugs through our preferred mail order pharmacy	<b>\$10</b>	<b>\$40</b>	<b>\$80</b>
10 day supply of	<b>\$5</b>	<b>\$20</b>	<b>\$40</b>

covered prescription drugs from an out-of-network pharmacy, obtained due to special circumstances

**Amount you pay between \$2,830 in total covered prescription drug expenses, and until you reach \$4,550 in out-of-pocket covered prescription drug costs.**

**(This may be referred to as the “Coverage Gap”.)**

<b>Prescription Drug/Medicine Quantity</b>	<b>Generic Prescription drugs</b>	<b>Preferred Brand Prescription drugs</b>	<b>Non-preferred Brand Prescription drugs</b>
1 month supply (31 days) of covered prescription drugs at a network retail pharmacy	<b>\$5</b>	<b>You pay 100%</b>	<b>You pay 100%</b>
3 month supply (90 day) supply of covered prescription drugs at a network retail; or through a non-preferred mail order pharmacy	<b>\$15</b>	<b>You pay 100%</b>	<b>You pay 100%</b>
90 day supply of covered prescription drugs through our preferred mail order pharmacy	<b>\$10</b>	<b>You pay 100%</b>	<b>You pay 100%</b>
10 day supply of covered prescription drugs from an out-of-network pharmacy, obtained due to special circumstances	<b>\$5</b>	<b>You pay 100%</b>	<b>You pay 100%</b>

**Amount you pay for covered prescription drugs after reaching \$4,550 in out-of-pocket prescription drugs costs. (This may be referred to as the “Catastrophic Coverage Level”).**

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	You pay the greater of: <b>\$2.50</b> for covered Generic drugs (including Brand drugs treated as Generic); <b>\$6.30</b> for all others; or <b>5%</b>

For full information on the benefits, limitations and exclusions provided under this Prescription Drug Schedule of Copayments/Coinsurance, please refer to your Evidence of Coverage, or call the Member Services Department at the number on your ID card, or TTY/TDD 1-800-628-3323.

**You may be eligible for help with your costs:**

**Medicare** beneficiaries with low or limited income and resources, may qualify for additional assistance. If you qualify, your Medicare prescription drug plan costs, if any, may be less. Once you have enrolled in our plan, Medicare will tell us how much assistance you are receiving, and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact 1-800-Medicare to see if you might qualify.

**Network Pharmacies:**

The Aetna Medicare Rx Plan has formed a network of pharmacies. You must use a Network Pharmacy to receive plan benefits. The Aetna Medicare Rx Plan may not pay for your prescriptions if you use an Out-of-Network Pharmacy, except in certain cases.

**This Plan uses a Closed or Standard Formulary:**

Your plan uses either a Closed or the Standard Formulary, which means that only drugs on Aetna’s Preferred Drug List will be covered under your plan as long as the drug is medically necessary and the plan rules are followed. If it is Medically Necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit but is not on our Formulary, you can contact Aetna to request coverage exception. Your doctor must submit a statement supporting your exception request.

**Aetna** receives rebates from the manufacturers of many drugs, including many that are on the **Formulary** Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage.

**Note:** *This plan does not cover any drug that does not, by federal or state law, require a prescription (i.e. an over-the-counter (OTC) drug), even when a prescription is written.*

Prescription drug coverage under this Prescription Drug Schedule of Copayments/Coinsurance is provided by Aetna Life Insurance Company.

**AETNA LIFE INSURANCE COMPANY  
WASHINGTON  
AETNA MEDICARE OPEN<sup>SM</sup> PLAN (PFFS)**

**SCHEDULE OF COPAYMENTS**

**Contract Holder Name:** The City Of Seattle  
**Contract Holder Group Agreement Effective Date:** January 1, 2010  
**Contract Holder Number:** 395280

**Deductible Amount** **None**

**Calendar Year Out-of-Pocket Maximum  
Maximum for Covered Benefits  
Includes deductible** **\$2,000 per calendar year**

**OUTPATIENT BENEFITS**

<u><b>Benefit</b></u>	<u><b>Copayment/Coinsurance</b></u>
<b>Primary Care Physician</b>	
<b>Office Visit</b>	<b>\$20 per visit</b>
<b>Home or After-Office Hours Visit</b>	<b>\$20 per visit</b>
<b>Immunizations:</b> (Copayment/coinsurance and deductible are waived for immunizations for flu, pneumonia, Hepatitis B)	<b>\$0 per visit</b>
<b>Specialist Physician Visit</b>	
<b>Office Visit</b>	<b>\$20 per visit</b>

## **Preventive Services**

<b>Annual Routine Physical</b> 1 exam per calendar year	<b>\$0 per visit</b>
<b>Colorectal Screenings</b> 1 exam per calendar year	<b>\$0 per visit</b>
<b>Bone Mass Measurement</b> 1 exam per calendar year	<b>\$0 per visit</b>
<b>Annual Prostate Screening</b> 1 exam per calendar year	<b>\$0 per visit</b>
<b>Mammogram (Annual Screening)</b> (For Women with Medicare age 40 and older) 1 exam per calendar year	<b>\$0 per visit</b>
<b>Chiropractic Visit</b> Manual manipulation of the spine only to the extent covered by Medicare	<b>\$20 per visit</b>
<b>Podiatry Visit</b> (Medically necessary visit to the extent that is covered by Medicare)	<b>\$20 per visit</b>
<b>Routine Vision Exam</b> 1 exam per calendar year	<b>\$0 per exam</b>

<b>Diagnostic Eye Exam</b>	<b>\$20 per exam</b>
<b>Routine Hearing Exam</b> 1 exam per calendar year	<b>\$0 per exam</b>
<b>Diagnostic Hearing Exam</b>	<b>\$20 per exam</b>
<b>Routine Gynecological Exam</b> 1 exam per calendar year	<b>\$0 per exam</b>
<b>Gynecology</b>	<b>\$20 per exam</b>
<b>Outpatient Rehabilitation Benefits</b> Outpatient Physical Therapy, Occupational Therapy, and Speech and Language Therapy	<b>\$20 per visit</b>
<b>Outpatient Chemotherapy and Outpatient Radiation</b>	<b>\$20 per visit</b>
<b>Dialysis</b>	<b>\$20 per visit</b>
<b>Diagnostic Testing - Laboratory</b>	<b>\$20 per test</b>
<b>Diagnostic Testing - X-Ray</b>	<b>\$20 per test</b>
<b>Complex Imaging -</b>	<b>\$20 per test</b>

**PET Scans, CAT Scans, MRI**

**Outpatient Emergency Services**  
(Emergency Services copayment is waived if admitted)

**\$50 per visit**

**Outpatient Urgently Needed Care Services**

**\$20 per visit**

**Ambulance**

**\$20 per trip**

**Durable Medical Equipment**

**20% of the cost of each Medicare covered item**

**Prosthetic Devices**

**20% of the cost of each Medicare covered item**

**Diabetes Self-monitoring, Training, And Supplies**

**\$0 per item, visit**

**Medical Nutrition Therapy**

**\$0 per visit**

**Outpatient Mental Health Visits**

**\$20 per visit**

**Outpatient Substance Abuse Visits**

**\$20 per visit**

**Outpatient Surgery**

**Ambulatory Surgical Center**

**\$0 per visit  
to an ambulatory surgical center**

**Outpatient Hospital Facility**

**\$0 per visit to any outpatient hospital  
facility**

**Outpatient Home Health Visits**

**\$0 per visit**

**Outpatient Hospice**

**Hospice services are paid for by Original  
Medicare**

**Medicare Covered Injectables and  
Medicare Covered Oral Drugs**

(Those injectables and drugs required to be  
covered by Medicare)  
(Office visit may also apply)

**\$0 per prescription or refill**

**INPATIENT BENEFITS**

**Benefits**

**Copayment/Coinsurance**

**Inpatient Hospital Care**

Unlimited days

**\$250 per admission**

**Transplants**

(Coverage may be provided through the  
Institute of Excellence Network)

Unlimited days

**Hospital Care Copayment Applies**

**Inpatient Mental Health**  
Unlimited days

**\$250 per admission**

**Substance Abuse  
Detoxification and Rehabilitation**  
Unlimited days

**\$250 per admission**

**Residential Treatment Facility**  
Unlimited days

**\$0 per day for days 1 - 10**

**\$25 per day for days 11 - 20**

**\$50 per day for days 21 - 999**

**Skilled Nursing Facility-**  
100 days per benefit period

**\$0 per day for days 1 - 10**

**\$25 per day for days 11 - 20**

**\$50 per day for days 21 - 100**

**Inpatient Hospice**  
Unlimited days

**Hospice services are paid for by Original  
Medicare**

**ADDITIONAL BENEFITS**

**Informed Health Line**

**Included  
Medical Management Program**

**Health/Wellness Education Benefit**

**Coaching**

**1 session per week**

**Aetna recommends that you receive Precertification for certain services. The services for which Aetna recommends Precertification are: Inpatient Hospital, Inpatient Mental**

**Health, Inpatient Substance Abuse, Skilled Nursing Facility, Home Health Care and certain DME.**

**For full information on the benefits provided under this Certificate, please refer to your Evidence of Coverage and Schedule of Copayments, or call the Member Services Department at the number on your ID card (TTY/TDD # 1-888-760-4748).**