


Aetna Medicare


Former Employer/Union/Trust Name: **State Teachers Retirement System of Ohio**
 Group Agreement Effective Date: **01/01/2025**
 Master Plan ID: **0000521, 0015111**

This *Schedule of Cost Sharing* is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the document with information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.) If you have questions, please call our Member Services at the telephone number printed on your member ID card or call our Member Services at 1-833-383-4612. (TTY users should call [711](tel:711).) Hours are 8 AM to 9 PM ET, Monday through Friday.


| Annual Deductible | FOR SERVICES RECEIVED IN-NETWORK | FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED |
|--|-------------------------------------|---|
| This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered medical services. | No Deductible | \$500 deductible The annual combined (plan level) deductible does not apply to the following out-of-network services: Preventive services, additional Medicare covered preventive services, Part B Insulin, emergency room visits, emergency ambulance, urgent care and wigs. |
| Annual Maximum Out-of-Pocket Limit | FOR SERVICES RECEIVED IN-NETWORK | FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED |
| The maximum out-of-pocket limit is the most you will pay for covered medical services including any deductible (if applicable). The amounts you pay for covered services received from network and out-of-network providers count toward the in-network maximum out-of-pocket amount. | \$1,500 | \$2,500 |




Medical Benefits Chart




 You will see this apple next to the Medicare-covered preventive services in the benefits chart.

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p> Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> | <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> | <p>\$0 copay for members eligible for this preventive screening.</p> |
| <p>Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a | <p>\$25 copay for services received in a PCP office setting.</p> <p>4% of the total cost for services received in a specialist office setting or an outpatient facility.</p> | <p>\$55 copay for services received in a PCP office setting.</p> <p>8% of the total cost for services received in a specialist office setting or an outpatient facility.</p> |
| <p><i>This service is continued on the next page</i></p> | | |




| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Acupuncture for chronic low back pain (<i>continued</i>)</p> <p>school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</p> <ul style="list-style-type: none"> • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> | | |
| <p>Acupuncture services (additional) In addition to the acupuncture services described above, we cover:</p> <ul style="list-style-type: none"> • Acupuncture services in place of anesthesia for a surgical or dental procedure covered under the plan • Services for the relief of chronic pain • unlimited visits every year <p>Note: (i) Services must be medically necessary. (ii) Services must be provided by appropriately licensed individuals practicing within the scope of their license.</p> | <p>\$25 copay for services received in a PCP office setting.</p> <p>4% of the total cost for services received in a specialist office setting or an outpatient facility.</p> | <p>You pay a \$55 copay for services received in a PCP office setting.</p> <p>You pay 8% of the total cost for services received in a specialist office setting or an outpatient facility.</p> |
| <p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan. • If the covered ambulance services are not for an emergency situation, it should be documented that the member’s condition is such that other means of transportation could endanger the person’s health and that | <p>4% of the total cost for each Medicare-covered one-way trip via ground or air ambulance.</p> <p>Ground or air ambulance cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> | <p>8% of the total cost for each Medicare-covered one-way trip via ground or air ambulance.</p> <p>Ground or air ambulance cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Ambulance services (<i>continued</i>)</p> <p>transportation by ambulance is medically required.</p> <p>Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.</p> | | |
| <p>Annual routine physical</p> <p>The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam.</p> <p>Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to Medicare preventive visit. You may schedule your annual routine physical once each calendar year.</p> <p>Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. (See Outpatient diagnostic tests and therapeutic services and supplies for more information.)</p> | \$0 copay for an annual routine physical exam. | \$0 copay for an annual routine physical exam. |
| <p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.</p> | There is no coinsurance, copayment, or deductible for the annual wellness visit. | \$0 copay for the annual wellness visit. |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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|  Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results. | There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. | \$0 copay for Medicare-covered bone mass measurement. |
|  Breast cancer screening (mammograms) Covered services include: <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women aged 40 and older • Clinical breast exams once every 24 months <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | There is no coinsurance, copayment, or deductible for covered screening mammograms. \$0 copay for each diagnostic mammogram. | \$0 copay for covered screening mammograms. 8% of the total cost for each diagnostic mammogram. |
| Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | \$25 copay for services received in an office setting. 4% of the total cost for services received in an outpatient facility. \$25 for each Medicare-covered intensive cardiac rehabilitation visit received in an office setting. 4% for each Medicare-covered intensive cardiac rehabilitation visit received in an outpatient facility. | \$55 copay for services received in an office setting. 8% of the total cost for services received in an outpatient facility. \$55 for each Medicare-covered intensive cardiac rehabilitation visit received in an office setting. 8% for each Medicare-covered intensive cardiac rehabilitation visit received in an outpatient facility. |
|  Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) <i>This service is continued on the next page</i> | There is no coinsurance, copayment, or deductible for the intensive | \$0 copay for the intensive behavioral therapy cardiovascular disease |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) (continued)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p> | <p>behavioral therapy cardiovascular disease preventive benefit.</p> | <p>preventive benefit.</p> |
| <p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p> | <p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p> | <p>\$0 copay for cardiovascular disease testing that is covered once every 5 years.</p> |
| <p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 24 months If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months | <p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p> | <p>\$0 copay for Medicare-covered preventive Pap and pelvic exams.</p> |
| <p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>4% of the total cost for each Medicare-covered chiropractic visit.</p> | <p>8% of the total cost for each Medicare-covered chiropractic visit.</p> |
| <p> Colorectal cancer screening</p> <p>The following tests are covered:</p> <ul style="list-style-type: none"> Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium | <p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy.</p> <p>\$0 copay for each Medicare-covered barium enema.</p> | <p>\$0 copay for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy.</p> <p>\$0 copay for each Medicare-covered barium enema.</p> |
| <p><i>This service is continued on the next page</i></p> | <p>Diagnostic colonoscopy:</p> | <p>Diagnostic colonoscopy is subject to the Outpatient</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Colorectal cancer screening <i>(continued)</i></p> <ul style="list-style-type: none"> • enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Twice per calendar year. • Screening Guaiac-based fecal occult blood test (gFOBT) for patients 45 years and older. Twice per calendar year. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. <p>Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.</p> | <p>\$0 copay</p> <p>Please note: If a polyp is removed or a biopsy is performed during a Medicare-covered screening or diagnostic colonoscopy, the polyp removal and associated pathology will be covered at \$0 copay.</p> | <p>surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers cost-sharing amount. If you have had polyps removed during a previous colonoscopy or have a condition that is monitored via colonoscopy (such as a prior history of colon cancer), ongoing colonoscopies are considered diagnostic.</p> <p>Please note: If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology will be covered subject to the outpatient surgery cost sharing. (See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information.)</p> |
| <p>Compression stockings</p> <p>Compression garments are usually made of elastic material, and are used to promote venous or lymphatic circulation. Compression garments worn on the legs can help prevent deep vein thrombosis and reduce edema, and are useful in a variety of peripheral vascular conditions.</p> <p>We cover unlimited singles/pairs every year.</p> | <p>4% of the total cost.</p> | <p>8% of the total cost.</p> |
| <p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays)</p> <p><i>This service is continued on the next page</i></p> | <p>\$25 copay for each Medicare-covered dental care service.</p> | <p>\$55 copay for each Medicare-covered dental care service.</p> |


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| <p>Dental services (<i>continued</i>)</p> <p>are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | | |
| <p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p> | <p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p> | <p>\$0 copay for an annual depression screening visit.</p> |
| <p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p> | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p> | <p>\$0 copay for the Medicare-covered diabetes screening tests.</p> |
| <p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. For people with diabetes who have severe | <p>\$0 copay for each Medicare-covered supply to monitor blood glucose.</p> <p>\$0 copay for each pair of Medicare-covered diabetic shoes and inserts.</p> <p>\$0 copay for Medicare-covered diabetes self-management</p> | <p>\$0 copay for each Medicare-covered supply to monitor blood glucose.</p> <p>\$0 copay for each pair of Medicare-covered diabetic shoes and inserts.</p> <p>\$0 copay for Medicare-covered diabetes self-management</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Diabetes self-management training, diabetic services and supplies <i>(continued)</i></p> <p>diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</p> <ul style="list-style-type: none"> Diabetes self-management training is covered under certain conditions. <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>training.</p> | <p>training.</p> |
| <p>Durable medical equipment (DME) and related supplies</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>Continuous glucose monitors (CGMs) and supplies are available through participating DME providers. For a list of DME providers, visit www.aetna.com/dsepublicContent/assets/pdf/en/DME_National_Provider_Listing.pdf.</p> <p>Dexcom and FreeStyle Libre continuous glucose monitors and supplies are also available at participating pharmacies.</p> <p>Your provider must obtain authorization for a continuous glucose monitor. Sensors can be obtained without prior authorization from the plan.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special-order it for you. The most recent list of participating pharmacies and suppliers is available on our</p> <p><i>This service is continued on the next page</i></p> | <p>4% of the total cost for each Medicare-covered durable medical equipment item.</p> <p>\$0 copay for continuous glucose monitors.</p> | <p>8% of the total cost for each Medicare-covered durable medical equipment item.</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Durable medical equipment (DME) and related supplies (<i>continued</i>)</p> <p>website at: STRS.AetnaMedicare.com.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | | |
| <p>Emergency care Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>This coverage is available worldwide (i.e., outside of the United States).</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Emergency care (worldwide) • Emergency ambulance services (worldwide) <p>You may have to pay the provider at the time of service and submit for reimbursement.</p> | <p>\$75 copay for each emergency room visit.</p> <p>Cost sharing <u>is</u> waived if you are immediately admitted to the hospital.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized.</p> <p>\$75 copay for each emergency room visit worldwide (i.e., outside the United States).</p> <p>Cost sharing <u>is</u> waived if you are admitted to the hospital.</p> <p>4% of the total cost for each one-way trip via ground or air ambulance worldwide (i.e., outside</p> | <p>\$75 copay for each emergency room visit.</p> <p>Cost sharing <u>is</u> waived if you are immediately admitted to the hospital.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized.</p> <p>\$75 copay for each emergency room visit worldwide (i.e., outside the United States).</p> <p>Cost sharing <u>is</u> waived if you are admitted to the hospital.</p> <p>4% of the total cost for each one-way trip via ground or air ambulance worldwide (i.e., outside</p> |

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| | <p>the United States).</p> <p>Cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> | <p>the United States).</p> <p>Cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> |
| <p>End stage renal disease transportation benefit Eligibility requirements</p> <p>If you qualify under Federal Medicare as being diagnosed with end stage renal disease (ESRD), you may be eligible for additional benefits to help you manage your condition.</p> <p>Transportation services (non-emergency)</p> <p>If you are diagnosed with ESRD, you get unlimited one-way trips every plan year to any covered medical appointment. This benefit is administered through Access2Care.</p> <p>To schedule a ride, just give Access2Care a call at 1-855-814-1699 (TTY: 711), 7 AM to 8 PM local time, at least two business days before your scheduled appointment. An Access2Care representative will schedule your ride through a transportation service (like a taxi or transport van) or rideshare service (like Uber or Lyft). There is a 60-mile limit for each one-way ride.</p> <p>Tip: Be sure to schedule a ride both to and from your destination. This will count as two one-way rides.</p> <p>Note: These rides are available to you only if you are eligible. If eligible, these rides are in addition to any rides you have received as part of your standard transportation benefit, listed in the Medical Benefits Chart.</p> | <p>\$0 copay per trip.</p> | <p>The in-network provider must be used for the transportation services benefit.</p> |
| <p>Fitness program (physical fitness)</p> <p>You are covered for a basic membership to any SilverSneakers® participating fitness facility.</p> <p>If you do not reside near a participating facility, or prefer to exercise at home, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers.</p> <p>You will also have access to online enrichment</p> <p><i>This service is continued on the next page</i></p> | <p>\$0 copay for health club membership/fitness classes.</p> | <p>\$0 copay for at-home fitness kits ordered through SilverSneakers. There are no out-of-network facilities available for this benefit.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Fitness program (physical fitness) (continued) classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self-help, and staying connected. These classes can be accessed online by visiting SilverSneakers.com.</p> <p>To get started, you will need your SilverSneakers ID number. Please visit SilverSneakers.com or call SilverSneakers at 1-855-627-3795 (TTY: 711) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers.</p> | | |
| <p> Health and wellness education programs</p> <ul style="list-style-type: none"> • 24-Hour Nurse Line: You can talk to a registered nurse 24 hours a day, 7 days a week on the 24/7 Nurse Line. They can help with health-related questions when your doctor is not available. Call 1-855-493-7019 (TTY: 711). The registered nurse staff cannot diagnose, prescribe or give medical advice. If you need urgent or emergency care, call 911 and/or your doctor immediately. • Health education: You can meet with a certified health educator or other qualified health professional to learn about health and wellness topics like: diabetes management, nutrition counseling, asthma education, and more. You have the option to meet one-on-one, in a group, or virtually. Ask your provider for information on how these services may help you. | <p>There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line benefit.</p> <p>Health education is included in your plan.</p> | <p>The in-network provider must be used for the 24-Hour Nurse Line benefit.</p> <p>Health education is included in your plan.</p> |
| <p>Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>In addition to Medicare-covered benefits, we also <i>This service is continued on the next page</i></p> | <p>\$25 copay for each Medicare-covered hearing exam.</p> <p>\$0 copay for each non-Medicare covered hearing exam.</p> | <p>\$55 copay for each Medicare-covered hearing exam.</p> <p>\$0 copay for each non-Medicare covered hearing exam.</p> |

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| <p>Hearing services <i>(continued)</i></p> <p>offer:</p> <ul style="list-style-type: none"> • Routine hearing exams: one exam every twelve months | | |
| <p>Hearing services - Hearing aids</p> <p>This is a reimbursement benefit towards the cost of hearing aids. You may see any licensed hearing provider in the U.S. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment. If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing information, which will delay the processing time.</p> <p>Notes:</p> <ul style="list-style-type: none"> • If you use a non-licensed provider, you will not receive reimbursement. • You are responsible for any charges above the reimbursement amount. <p><i>* Amounts you pay for hearing aids do not apply to your In-Network or Combined Out-of-Pocket Maximum.</i></p> | <p>Our plan will reimburse you up to \$1,000 once every 36 months towards the cost of hearing aids.</p> | |
| <p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy | <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p> | <p>\$0 copay for members eligible for Medicare-covered preventive HIV screening.</p> |
| <p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be</p> <p><i>This service is continued on the next page</i></p> | <p>\$0 copay for each Medicare-covered home health visit.</p> <p>4% of the total cost for each Medicare-covered</p> | <p>8% of the total cost for each Medicare-covered home health visit.</p> <p>8% of the total cost for each Medicare-covered</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Home health agency care (<i>continued</i>) homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing • Home health aide services when combined with skilled care and provided by a provider who is eligible to provide services under Medicare • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p>(To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>durable medical equipment item.</p> | <p>durable medical equipment item.</p> |
| <p>Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit | <p>You will pay the cost sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services.</p> <p>(See Physician/Practitioner services, including doctor's office visits or Home health agency care for any applicable cost sharing.)</p> <p>Please note that home infusion pumps and devices provided during a</p> | <p>You will pay the cost sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services.</p> <p>(See Physician/Practitioner Services, Including Doctor's Office Visits or Home Health Agency Care for any applicable cost sharing.)</p> <p>Please note that home infusion pumps and devices provided during a</p> |
| <p><i>This service is continued on the next page</i></p> | | |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Home infusion therapy <i>(continued)</i></p> <ul style="list-style-type: none"> • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | <p>home infusion therapy visit are covered separately under your Durable medical equipment (DME) and related supplies benefit.</p> | <p>home infusion therapy visit are covered separately under your Durable medical equipment (DME) and related supplies benefit.</p> |
| <p>Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p> | <p>You pay a \$0 copay for hospice services received by a Medicare-certified hospice facility that are related to your terminal prognosis.</p> <p>Hospice consultations are included as part of inpatient hospital care.</p> <p>Physician service cost sharing may apply for outpatient consultations.</p> | <p>You pay a \$0 copay for hospice services received by a Medicare-certified hospice facility that are related to your terminal prognosis.</p> <p>Hospice consultations are included as part of inpatient hospital care.</p> <p>Physician service cost sharing may apply for outpatient consultations.</p> |
| <p> Immunizations Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules | <p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p> <p>\$0 copay for other Medicare-covered Part B vaccines.</p> <p>You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated.</p> | <p>\$0 copay for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p> <p>\$0 copay for other Medicare-covered Part B vaccines.</p> <p>You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated.</p> |
| <p>In-home support services You will be eligible for the following in-home <i>This service is continued on the next page</i></p> | <p>\$0 copay for members eligible for in-home support services.</p> | <p>Not Covered</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>In-home support services <i>(continued)</i></p> <p>support benefit when you meet the eligibility criteria below. This added benefit will cover assistance with meal preparation, light housekeeping such as assistance with your bed, or small household tasks, assisting you to walk or move around, assisting you with personal care and hygiene, medication reminders, and other activities of daily living that are focused on improving or maintaining the status of your health. In order to be eligible, you must meet the following criteria:</p> <ul style="list-style-type: none"> • Have been discharged from an inpatient acute or non-acute facility within the past 30 days • Receive a referral from a Utilization Manager or Care Management to qualify for the benefit • Have one of the 15 CMS-defined chronic conditions <p>Please call your care team for more information on this benefit and to see if you are eligible. Services are only provided by our contracted vendor, The Helper Bees. If you qualify, after discharge, The Helper Bees will reach out to you to set up the services.</p> <p>We cover up to 6 hours per discharge to be used within 30 days of discharge.</p> | | |
| <p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets | <p>For each inpatient hospital stay, you pay: 4% per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p> | <p>For each inpatient hospital stay, you pay: 8% per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Inpatient hospital care <i>(continued)</i></p> <ul style="list-style-type: none"> • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of</p> <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Inpatient hospital care (<i>continued</i>)</p> <p>the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | | |
| <p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>For each inpatient stay, you pay: 4% per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> | <p>For each inpatient stay, you pay: 8% per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> |
| <p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your skilled nursing facility benefits or if the skilled nursing facility or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF).</p> <p>Covered services include, but are not limited to:</p> <p><i>This service is continued on the next page</i></p> | <p>\$0 copay for Medicare-covered primary care physician (PCP) services.</p> <p>\$25 copay for Medicare-covered specialist services.</p> <p>4% of the total cost for each Medicare-covered diagnostic procedure and test.</p> | <p>\$40 copay for Medicare-covered primary care physician (PCP) services.</p> <p>\$55 copay for Medicare-covered specialist services.</p> <p>8% of the total cost for each Medicare-covered diagnostic procedure and test.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>\$0 copay for each Medicare-covered lab service.</p> <p>4% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>4% of the total cost for each Medicare-covered x-ray.</p> <p>4% of the total cost for each Medicare-covered therapeutic radiology service.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay for continuous glucose meter supplies.</p> <p>4% of the total cost for each Medicare-covered prosthetic and orthotic device.</p> <p>4% of the total cost for each Medicare-covered physical or speech therapy visit.</p> <p>4% of the total cost for each Medicare-covered occupational therapy visit.</p> | <p>\$0 copay for each Medicare-covered lab service.</p> <p>8% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>8% of the total cost for each Medicare-covered x-ray.</p> <p>8% of the total cost for each Medicare-covered therapeutic radiology service.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>8% of the total cost for each Medicare-covered prosthetic and orthotic device.</p> <p>8% of the total cost for each Medicare-covered physical or speech therapy visit.</p> <p>8% of the total cost for each Medicare-covered occupational therapy visit.</p> |
| <p> Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under</p> <p><i>This service is continued on the next page</i></p> | <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> | <p>\$0 copay for Medicare-covered medical nutrition therapy services.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Medical nutrition therapy <i>(continued)</i></p> <p>Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p> | | |
| <p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p> | <p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p> | <p>\$0 copay for the Medicare-covered MDPP benefit.</p> |
| <p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.</p> <p>Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment | <p>\$0 copay per prescription or refill.</p> <p>\$0 copay for each chemotherapy or infusion therapy Part B drug.</p> <p>\$25 copay for the administration of the chemotherapy drug as well as for infusion therapy.</p> <p>\$0 copay for each allergy shot. You may have to pay an office visit cost share if you get other services at the same time that you get the allergy shot.</p> <p>\$0 copay for each insulin Part B drug.</p> <p>Part B drugs may be subject to Step Therapy requirements.</p> | <p>\$0 copay per prescription or refill.</p> <p>\$0 copay for each chemotherapy or infusion therapy Part B drug.</p> <p>\$55 copay for the administration of the chemotherapy drug as well as for infusion therapy.</p> <p>\$0 copay for each allergy shot. You may have to pay an office visit cost share if you get other services at the same time that you get the allergy shot.</p> <p>\$0 copay for each insulin Part B drug.</p> <p>Part B drugs may be subject to Step Therapy</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Medicare Part B prescription drugs <i>(continued)</i></p> <ul style="list-style-type: none"> • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen[®], Procrit[®], Epoetin Alfa, Aranesp[®], or Darbepoetin Alfa) • Erythropoiesis-stimulating agents: Medicare | | <p>requirements.</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Medicare Part B prescription drugs <i>(continued)</i></p> <p>covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta).</p> <ul style="list-style-type: none"> • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) • Allergy shots <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: Aetna.com/partb-step.</p> <p>We also cover some vaccines under our Part B prescription drug benefit.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | | |
| <p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p> | <p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p> | <p>\$0 copay for preventive obesity screening and therapy.</p> |
| <p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications | <p>\$25 copay for each Medicare-covered opioid use disorder treatment service.</p> | <p>\$55 copay for each Medicare-covered opioid use disorder treatment service.</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Opioid treatment program services <i>(continued)</i></p> <ul style="list-style-type: none"> • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | | |
| <p>Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>4% of the total cost for each Medicare-covered x-ray.</p> <p>X-rays that are done in a physician/specialist office are subject to the applicable physician/specialist cost-sharing amount.</p> <p>4% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>Diagnostic radiology and complex imaging services that are done in a</p> | <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>8% of the total cost for each Medicare-covered x-ray.</p> <p>X-rays that are done in a physician/specialist office are subject to the applicable physician/specialist cost-sharing amount.</p> <p>8% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>Diagnostic radiology and complex imaging services that are done in a physician/specialist office</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| | <p>physician/specialist office is subject to the applicable physician/specialist cost-sharing amount.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>\$0 copay for Medicare-covered blood services.</p> <p>4% of the total cost for each Medicare-covered diagnostic procedure and test.</p> <p>4% of the total cost for each Medicare-covered CT scan.</p> <p>4% of the total cost for each Medicare-covered diagnostic service other than CT scan.</p> <p>\$0 copay for each Medicare-covered retinal fundus service, spirometry, and peripheral arterial disease (PAD).</p> <p>4% of the total cost for each Medicare-covered therapeutic radiology service.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay for continuous glucose meter supplies.</p> | <p>is subject to the applicable physician/specialist cost-sharing amount.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>8% of the total cost for Medicare-covered blood services.</p> <p>8% of the total cost for each Medicare-covered diagnostic procedure and test.</p> <p>8% of the total cost for each Medicare-covered CT scan.</p> <p>8% of the total cost for each Medicare-covered diagnostic service other than CT scan.</p> <p>8% of the total cost for each Medicare-covered therapeutic radiology service.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> | <p>Your cost share for Observation Care is based upon the services you receive.</p> | <p>Your cost share for Observation Care is based upon the services you receive.</p> |
| <p>Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it | <p>4% of the total cost of the facility visit.</p> <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$75 copay for each emergency room visit.</p> | <p>8% of the total cost of the facility visit.</p> <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$75 copay for each emergency room visit.</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Outpatient hospital services (<i>continued</i>)</p> <ul style="list-style-type: none"> • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>Cost sharing <u>is</u> waived if you are immediately admitted to the hospital.</p> <p>4% of the total cost for each Medicare-covered diagnostic procedure and test.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>4% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>4% of the total cost for each Medicare-covered x-ray.</p> <p>4% of the total cost for each Medicare-covered therapeutic radiology service.</p> <p>\$25 copay for each Medicare-covered individual session for outpatient psychiatrist services.</p> <p>\$25 copay for each Medicare-covered group session for outpatient psychiatrist services.</p> <p>\$25 copay for each Medicare-covered individual session for outpatient mental health services.</p> <p>\$25 copay for each Medicare-covered group session for outpatient mental health services.</p> | <p>Cost sharing <u>is</u> waived if you are immediately admitted to the hospital.</p> <p>8% of the total cost for each Medicare-covered diagnostic procedure and test.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>8% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>8% of the total cost for each Medicare-covered x-ray.</p> <p>8% of the total cost for each Medicare-covered therapeutic radiology service.</p> <p>\$55 copay for each Medicare-covered individual session for outpatient psychiatrist services.</p> <p>\$55 copay for each Medicare-covered group session for outpatient psychiatrist services.</p> <p>\$55 copay for each Medicare-covered individual session for outpatient mental health services.</p> <p>\$55 copay for each Medicare-covered group session for outpatient mental health services.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| | <p>\$25 copay for each Medicare-covered partial hospitalization visit or intensive outpatient visit.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay for continuous glucose meter supplies.</p> <p>\$0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.</p> | <p>\$55 copay for each Medicare-covered partial hospitalization visit or intensive outpatient visit.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.</p> |
| <p>Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p>We also cover some telehealth visits with psychiatric and mental health professionals. See Physician/Practitioner services, including doctor's office visits for information about telehealth outpatient mental health care.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>\$25 copay for each Medicare-covered individual session for outpatient psychiatrist services.</p> <p>\$25 copay for each Medicare-covered group session for outpatient psychiatrist services.</p> <p>\$25 copay for each Medicare-covered individual session for outpatient mental health services.</p> <p>\$25 copay for each Medicare-covered group session for outpatient mental health services.</p> | <p>\$55 copay for each Medicare-covered individual session for outpatient psychiatrist services.</p> <p>\$55 copay for each Medicare-covered group session for outpatient psychiatrist services.</p> <p>\$55 copay for each Medicare-covered individual session for outpatient mental health services.</p> <p>\$55 copay for each Medicare-covered group session for outpatient mental health services.</p> |
| <p>Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist</p> <p><i>This service is continued on the next page</i></p> | <p>4% of the total cost for each Medicare-covered physical or speech therapy visit.</p> <p>4% of the total cost for each Medicare-covered occupational therapy visit.</p> | <p>8% of the total cost for each Medicare-covered physical or speech therapy visit.</p> <p>8% of the total cost for each Medicare-covered occupational therapy visit.</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| Outpatient rehabilitation services (<i>continued</i>) offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). | | |
| Outpatient substance use disorder services Our coverage is the same as Original Medicare, which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: <ul style="list-style-type: none"> • Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | \$25 copay for each Medicare-covered individual outpatient substance use disorder service. \$25 copay for each Medicare-covered group outpatient substance use disorder service. | \$55 copay for each Medicare-covered individual outpatient substance use disorder service. \$55 copay for each Medicare-covered group outpatient substance use disorder service. |
| Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Prior authorization rules may apply for network <i>This service is continued on the next page</i> | Your cost share is based on: <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided 4% of the total cost for each Medicare-covered outpatient surgery at a | Your cost share is based on: <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided 8% of the total cost for each Medicare-covered outpatient surgery at a |




| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers <i>(continued)</i></p> <p>services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>hospital outpatient facility.</p> <p>4% of the total cost for each Medicare-covered outpatient surgery at an ambulatory surgical center.</p> | <p>hospital outpatient facility.</p> <p>8% of the total cost for each Medicare-covered outpatient surgery at an ambulatory surgical center.</p> |
| <p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s, therapist’s, licensed marriage and family therapist’s (LMFT), or licensed professional counselor’s office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor’s, therapist’s, licensed marriage and family therapist’s (LMFT), or licensed professional counselor’s office but less intense than partial hospitalization.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>\$25 copay for each Medicare-covered partial hospitalization visit or intensive outpatient visit.</p> | <p>\$55 copay for each Medicare-covered partial hospitalization visit or intensive outpatient visit.</p> |
| <p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays performed in a primary care or specialist office • Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a | <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$0 copay for</p> | <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$40 copay for</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Physician/Practitioner services, including doctor's office visits (<i>continued</i>)</p> <ul style="list-style-type: none"> specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: <ul style="list-style-type: none"> ◦ Primary care physician services ◦ Physician specialist services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services ◦ Occupational therapy services ◦ Physical and speech therapy services ◦ Opioid treatment services ◦ Outpatient substance use disorder services (individual sessions) ◦ Outpatient substance use disorder services (group sessions) ◦ Kidney disease education services ◦ Diabetes self-management services • For more details on your additional telehealth coverage, please review the Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth. <ul style="list-style-type: none"> ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. Not all providers offer telehealth services. ◦ You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc™, MinuteClinic Video Visit, or other | <p>Medicare-covered primary care physician (PCP) services (including urgently needed services).</p> <p>\$25 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services).</p> <p>Your cost share for cancer-related treatment is based upon the services you receive.</p> <p>\$25 copay for each Medicare-covered hearing exam.</p> <p>Certain additional telehealth services, including those for:</p> <ul style="list-style-type: none"> • \$0 copay for each primary care physician service • \$25 copay for each physician specialist service • \$25 copay for each mental health service (individual sessions) • \$25 copay for each mental health service (group sessions) • \$25 copay for each psychiatric service | <p>Medicare-covered primary care physician (PCP) services (including urgently needed services).</p> <p>\$55 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services).</p> <p>Your cost share for cancer-related treatment is based upon the services you receive.</p> <p>\$55 copay for each Medicare-covered hearing exam.</p> <p>Certain additional telehealth services, including those for:</p> <ul style="list-style-type: none"> • \$40 copay for each primary care physician service • \$55 copay for each specialist physician service • \$55 copay for each mental health service (individual sessions) • \$55 copay for each mental health service (group sessions) • \$55 copay for each psychiatric service |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Physician/Practitioner services, including doctor's office visits <i>(continued)</i></p> <p>provider that offers telehealth services covered under your plan. Members can access Teladoc at Teladoc.com/Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711), available 24/7. Note: Teladoc is not currently available outside of the United States and its territories (Guam, Puerto Rico, and the U.S. Virgin Islands). You can find out if MinuteClinic Video Visits are available in your area at CVS.com/MinuteClinic/virtual-care/videovisit.</p> <ul style="list-style-type: none"> • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while receiving these telehealth services • Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 | <p>(individual sessions)</p> <ul style="list-style-type: none"> • \$25 copay for each psychiatric service (group sessions) • \$40 copay for each urgently needed service • 4% of the total cost for each occupational therapy visit • 4% of the total cost for each physical and speech therapy visit • \$25 copay for each opioid treatment program service • \$25 copay for each individual outpatient substance use disorder service • \$25 copay for each group outpatient substance use disorder service • \$0 copay for each kidney disease education service • \$0 copay for each diabetes self-management training service <p>\$0 copay for each Teladoc telehealth service.</p> <p>\$25 copay for each</p> | <p>(individual sessions)</p> <ul style="list-style-type: none"> • \$55 copay for each psychiatric service (group sessions) • \$40 copay for each urgently needed service • 8% of the total cost for each occupational therapy visit • 8% of the total cost for each physical and speech therapy visit • \$55 copay for each opioid treatment program service • \$55 copay for each individual outpatient substance use disorder service • \$55 copay for each group outpatient substance use disorder service • \$0 copay for each kidney disease education service • \$0 copay for each diabetes self-management training service <p>\$55 copay for each Medicare-covered dental care service.</p> <p>\$55 copay for allergy</p> |
| <p><i>This service is continued on the next page</i></p> | | |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Physician/Practitioner services, including doctor's office visits (<i>continued</i>)</p> <p>minutes if:</p> <ul style="list-style-type: none"> ◦ You're not a new patient and ◦ The check-in isn't related to an office visit in the past 7 days and ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment <ul style="list-style-type: none"> • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ◦ You're not a new patient and ◦ The evaluation isn't related to an office visit in the past 7 days and ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing • Diagnosis, consultation and the treatment of cancer <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>Medicare-covered dental care service.</p> <p>\$25 copay for allergy testing services received in an office setting.</p> <p>4% of the total cost for allergy testing services received in an outpatient facility.</p> <p>\$15 copay for nationally contracted walk-in clinics.</p> | <p>testing services received in an office setting.</p> <p>8% of the total cost for allergy testing services received in an outpatient facility.</p> |
| <p>Podiatry services Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) | <p>\$25 copay for each Medicare-covered podiatry service.</p> | <p>\$55 copay for each Medicare-covered podiatry service.</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Podiatry services <i>(continued)</i></p> <ul style="list-style-type: none"> Routine foot care for members with certain medical conditions affecting the lower limbs | | |
| <p> Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months:</p> <ul style="list-style-type: none"> Digital rectal exam Prostate Specific Antigen (PSA) test | <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p> <p>\$0 copay for each Medicare-covered digital rectal exam.</p> | <p>\$0 copay for an annual PSA test.</p> <p>\$0 copay for each Medicare-covered digital rectal exam.</p> |
| <p>Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision care later in this section for more detail.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>4% of the total cost for each Medicare-covered prosthetic and orthotic device.</p> | <p>8% of the total cost for each Medicare-covered prosthetic and orthotic device.</p> |
| <p>Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> | <p>\$20 copay for each Medicare-covered pulmonary rehabilitation service.</p> | <p>\$55 copay for each Medicare-covered pulmonary rehabilitation service.</p> |
| <p>Resources for Living® Resources for Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in</p> <p><i>This service is continued on the next page</i></p> | <p>There is no coinsurance, copayment, or deductible for Resources for Living.</p> | <p>Resources for Living is included in your plan.</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Resources for Living® (<i>continued</i>)</p> <p>locating local community services and to provide resource information for a wide variety of eldercare and life-related issues. Call Resources for Living at 1-866-370-4842.</p> | | |
| <p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p> | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> | <p>\$0 copay for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> |
| <p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 50–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p> | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p> | <p>\$0 copay for the Medicare-covered counseling and shared decision making visit and for the LDCT.</p> |
| <p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI)</p> <p><i>This service is continued on the next page</i></p> | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs</p> | <p>\$0 copay for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p> |


| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
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| <p>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (<i>continued</i>)</p> <p>screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p> | <p>preventive benefit.</p> | |
| <p>Services to treat kidney disease Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the <i>Evidence of Coverage</i>, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) | <p>\$0 copay for self-dialysis training.</p> <p>\$0 copay for each Medicare-covered kidney disease education session.</p> <p>4% of the total cost for in- and out-of-area outpatient dialysis.</p> <p>For each inpatient hospital stay, you pay: 4% per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p> | <p>\$0 copay for self-dialysis training.</p> <p>\$0 copay for each Medicare-covered kidney disease education session.</p> <p>4% of the total cost for in- and out-of-area outpatient dialysis.</p> <p>For each inpatient hospital stay, you pay: 8% per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> <p>8% of the total cost for home dialysis equipment and supplies.</p> <p>8% of the total cost for Medicare-covered home support services.</p> |
| <p><i>This service is continued on the next page</i></p> | | |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
|--|---|--|
| <p>Services to treat kidney disease (<i>continued</i>)</p> <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, Medicare Part B prescription drugs.</p> <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | <p>4% of the total cost for home dialysis equipment and supplies.</p> <p>\$0 copay for Medicare-covered home support services.</p> | |
| <p>Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see the final chapter (“Definitions of important words”) of the <i>Evidence of Coverage</i>. Skilled nursing facilities are sometimes called SNFs.)</p> <p>A prior hospital stay is not required.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • 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 with the first pint of blood that you need. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from</p> <p><i>This service is continued on the next page</i></p> | <p>\$0 per day for each Medicare-covered SNF stay.</p> <p>You are allowed to stay in a skilled nursing facility as long as you require care that is needed on a daily basis and administered by a licensed, trained professional.</p> | <p>8% per day for each Medicare-covered SNF stay.</p> <p>You are allowed to stay in a skilled nursing facility as long as you require care that is needed on a daily basis and administered by a licensed, trained professional.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
|--|---|---|
| <p>Skilled nursing facility (SNF) care <i>(continued)</i></p> <p>network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital <p>Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.</p> | | |
| <p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Additional (non-Medicare covered) individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year | <p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <p>\$0 copay for each additional non-Medicare covered smoking and tobacco use cessation visit.</p> | <p>\$0 copay for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <p>\$0 copay for each additional non-Medicare covered smoking and tobacco use cessation visit.</p> |
| <p>Supervised Exercise Therapy (SET)</p> <p><i>This service is continued on the next page</i></p> | <p>\$20 copay for each Medicare-covered</p> | <p>\$55 copay for each Medicare-covered</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
|--|---|---|
| <p>Supervised Exercise Therapy (SET) (continued)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p> | Supervised Exercise Therapy service. | Supervised Exercise Therapy service. |
| <p>Transportation services (non-emergency transportation)</p> <p>We cover:</p> <ul style="list-style-type: none"> • 24 one-way trips to and from plan-approved locations each year <p>Trips must be within 60 miles of provider location.</p> <p>Coverage includes trips to and from providers or facilities for services that your plan covers. The transportation service will accommodate urgent requests for hospital discharge, dialysis, and trips that your medical provider considers urgent. The service will try to accommodate specific physical limitations or requirements. However, it limits services to wheelchair, taxi, or sedan</p> <p><i>This service is continued on the next page</i></p> | \$0 copay per trip. | The in-network provider must be used for the transportation services benefit. |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
|--|---|---|
| <p>Transportation services (non-emergency transportation) <i>(continued)</i></p> <p>transportation vehicles.</p> <ul style="list-style-type: none"> • Transportation services are administered through Access2Care • To arrange for transport, call 1-855-814-1699 (TTY: 711), Monday through Friday, 8 AM-8 PM • You must schedule transportation service at least 48 hours before the appointment • You must cancel more than two hours in advance, or Access2Care will deduct the trip from the remaining number of trips available • This program doesn't support stretcher vans/ambulances | | |
| <p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Urgent care (worldwide) <p>You may have to pay the provider at the time of service and submit for reimbursement.</p> | <p>\$40 copay for each urgent care facility visit.</p> <p>Cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> <p>\$40 copay for each urgent care facility visit worldwide (i.e., outside the United States).</p> <p>Cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> | <p>\$40 copay for each urgent care facility visit.</p> <p>Cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> <p>\$40 copay for each urgent care facility visit worldwide (i.e., outside the United States).</p> <p>Cost sharing is <u>not</u> waived if you are admitted to the hospital.</p> |
| <p> Vision care</p> <p>Covered services include:</p> <p><i>This service is continued on the next page</i></p> | <p>\$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> | <p>\$55 copay for exams to diagnose and treat diseases and conditions of the eye.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
|--|--|--|
| <p>Vision care (continued)</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening every 12 months. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Non-Medicare covered eye exams: one exam every year • Follow-up diabetic eye exam | <p>\$0 copay for each Medicare-covered glaucoma screening.</p> <p>\$0 copay for one diabetic retinopathy screening.</p> <p>\$0 copay for each follow-up diabetic eye exam.</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses, traditional lenses, bifocals, trifocals, progressive lenses, or contact lenses. Designer frames are excluded.</p> <p>\$0 copay for each non-Medicare covered eye exam.</p> <p>Additional cost sharing may apply if you receive additional services during your visit.</p> | <p>\$0 copay for each Medicare-covered glaucoma screening.</p> <p>\$0 copay for one diabetic retinopathy screening.</p> <p>\$0 copay for each follow-up diabetic eye exam.</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses, traditional lenses, bifocals, trifocals, progressive lenses, or contact lenses. Designer frames are excluded.</p> <p>\$0 copay for each non-Medicare covered eye exam.</p> <p>Additional cost sharing may apply if you receive additional services during your visit.</p> |
| <p> Welcome to Medicare preventive visit The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed.</p> <p>Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.</p> | <p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.</p> <p>\$0 copay for a Medicare-covered EKG screening following the Welcome to Medicare preventive visit.</p> | <p>\$0 copay for the Welcome to Medicare preventive visit.</p> <p>\$0 copay for a Medicare-covered EKG screening following the Welcome to Medicare preventive visit.</p> |
| <p>Wigs <i>This service is continued on the next page</i></p> | <p>\$0 copay for a wig.</p> | <p>\$0 copay for a wig.</p> |

| Services that are covered for you | What you must pay when you get these services in-network | What you must pay when you get these services out-of-network |
|---|--|--|
| <p>Wigs <i>(continued)</i></p> <p>This benefit is offered for hair loss as a result of chemotherapy.</p> <p>You can purchase wigs through a durable medical equipment (DME) supplier or supplier of your choice. Plan pays up to \$400 every year. You are responsible for any costs over the benefit amount.</p> <p>To find a DME supplier you can call the phone number on your Member ID card or visit our online directory at aet.na/search. If you choose to use a supplier that is not in the DME network, you will need to pay out-of-pocket and submit a claim for reimbursement along with the receipt. You will only be reimbursed up to the benefit amount. You can find the reimbursement form at AetnaMedicare.com/forms.</p> | | |

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

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health family of companies. Other providers are available in our network.
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Multi-Language Insert Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-383-4612. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-383-4612. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-833-383-4612。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-383-4612。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-383-4612. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-383-4612. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-383-4612. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-383-4612. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-383-4612. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-383-4612. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-383-4612. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-383-4612 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-383-4612. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-383-4612. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-383-4612. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-383-4612. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-833-383-4612. にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele 'ōlelo kā mākou i mea e pane 'ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā'au lapa'au paha. I mea e loa'a ai ke kōkua māhele 'ōlelo, e kelepona mai iā mākou ma 1-833-383-4612. E hiki ana i kekahi mea 'ōlelo Pelekānia/'Ōlelo ke kōkua iā 'oe. He pōmaika'i manuahi kēia.

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

Aetna Medicare Plan (PPO) Member Services

| Method | Member Services – Contact Information |
|----------------|--|
| CALL | The number on your member ID card or 1-833-383-4612 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers. |
| TTY | 711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday |
| WRITE | Aetna Medicare PO Box 7082 London, KY 40742 |
| WEBSITE | STRS.AetnaMedicare.com |

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **Addendum A** at the back of your *Evidence of Coverage* booklet.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

January 1 – December 31, 2025

Evidence of Coverage:

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

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-833-383-4612. (TTY users should call [711](#)). Hours are 8 AM to 9 PM ET, Monday through Friday. This call is free.

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

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2026.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

If you have any questions, please call Member Services at 1-833-383-4612.

2025 Evidence of Coverage

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CHAPTER 1: *Getting started as a member*

SECTION 1 Introduction

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

Your coverage is provided through a contract with the State Teachers Retirement System of Ohio (STRS Ohio). You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Aetna Medicare Plan (PPO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Aetna Medicare Plan (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. Aetna Medicare Plan (PPO) does not include Part D prescription drug coverage.

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

| | |
|-------------|---|
| Section 1.2 | What is the <i>Evidence of Coverage</i> document about? |
|-------------|---|

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words coverage and covered services refer to the medical care and services available to you as a member of Aetna Medicare Plan (PPO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Member Services.

| | |
|-------------|---|
| Section 1.3 | Legal information about the <i>Evidence of Coverage</i> |
|-------------|---|

This *Evidence of Coverage* is part of our contract with you about how Aetna Medicare Plan (PPO) covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in Aetna Medicare Plan (PPO) between January 1, 2025 and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Aetna Medicare Plan (PPO) after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Aetna Medicare Plan (PPO) each year. STRS Ohio can continue to offer you Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

If you have any questions, please call Member Services at 1-833-383-4612.

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you meet the eligibility requirements of STRS Ohio

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

Aetna Medicare Plan (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described in **Appendix B** at the back of this document.

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

If you move, please contact STRS Ohio.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

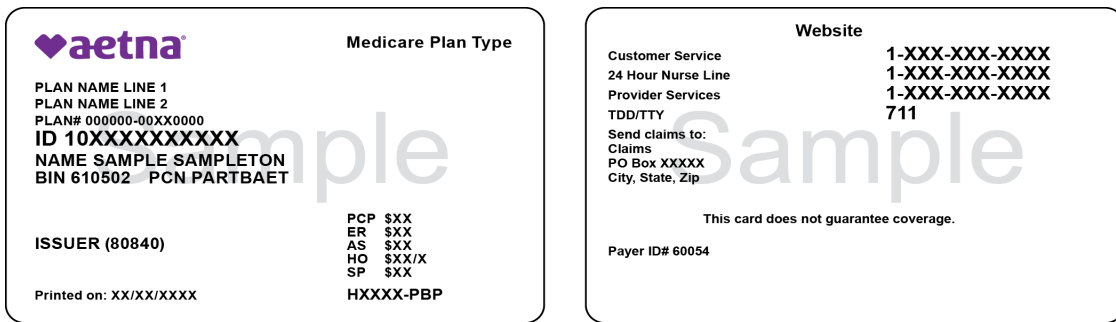
Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive**Section 3.1** Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

If you have any questions, please call Member Services at 1-833-383-4612.



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Aetna Medicare Plan (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Aetna Medicare Plan (PPO) authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at [STRS.AetnaMedicare.com](https://www.aetna.com/medicare).

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

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

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs*. If you need a copy you can download it from the Medicare website (www.medicare.gov/medicare-and-you). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call [1-877-486-2048](https://www.medicare.gov/medicare-and-you).

If you have any questions, please call Member Services at 1-833-383-4612.

Section 4.1 Plan premium

Your coverage is provided through a contract with STRS Ohio. STRS Ohio will let you know about your plan premium (if applicable).

Section 4.2 Monthly Medicare Part B Premium**Many members are required to pay other Medicare premiums**

In addition to paying the monthly plan premium (if applicable), **you must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B.

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

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

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services.

If you have any questions, please call Member Services at 1-833-383-4612.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

If you have any questions, please call Member Services at 1-833-383-4612.

CHAPTER 2: *Important phone numbers and resources*

SECTION 1 Aetna Medicare Plan (PPO) contacts (how to contact us, including how to reach Member Services)

How to contact our plan’s Member Services

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

| Method | Member Services – Contact Information |
|----------------|---|
| CALL | Please call 1-833-383-4612 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers. |
| TTY | 711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| FAX | 1-866-474-4040 |
| WRITE | Aetna Medicare PO Box 7082 London, KY 40742 |
| WEBSITE | STRS.AetnaMedicare.com |

How to contact us when you are asking for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Method | Coverage Decisions for Medical Care – Contact Information |
|----------------|--|
| CALL | Please call 1-833-383-4612 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| TTY | 711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| FAX | 1-866-759-4415 |
| WRITE | Aetna Medicare Precertification Unit PO Box 14079 Lexington, KY 40512 |
| WEBSITE | STRS.AetnaMedicare.com |

| Method | Appeals for Medical Care – Contact Information |
|--------|--|
|--------|--|

If you have any questions, please call Member Services at 1-833-383-4612.

| | |
|----------------|--|
| CALL | Please call 1-833-383-4612 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| TTY | 711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| FAX | Expedited appeals: 1-724-741-4958 Standard appeals: 1-724-741-4953 |
| WRITE | Aetna Medicare Part C Appeals PO Box 14067 Lexington, KY 40512 |
| WEBSITE | STRS.AetnaMedicare.com |

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Method | Complaints about Medical Care – Contact Information |
|-------------------------|---|
| CALL | Please call 1-833-383-4612 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| TTY | 711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| FAX | 1-724-741-4956 |
| WRITE | Aetna Medicare Grievances PO Box 14834 Lexington, KY 40512 |
| MEDICARE WEBSITE | You can submit a complaint about Aetna Medicare Plan (PPO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx . |

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

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

If you have any questions, please call Member Services at 1-833-383-4612.

| Method | Payment Requests for Medical Coverage – Contact Information |
|----------------|---|
| FAX | 1-866-474-4040 |
| WRITE | Aetna Medicare PO Box 981106 El Paso, TX 79998-1106 |
| WEBSITE | STRS.AetnaMedicare.com |

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

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

If you have any questions, please call Member Services at 1-833-383-4612.

WEBSITEwww.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about Aetna Medicare Plan (PPO):

- **Tell Medicare about your complaint:** You can submit a complaint about Aetna Medicare Plan (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call [1-877-486-2048](tel:1-877-486-2048).

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Refer to **Appendix A** at the back of this document for the name and contact information for the State Health Insurance Assistance Program in your state.

SHIP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare plan choices and answer questions about switching plans.

If you have any questions, please call Member Services at 1-833-383-4612.

METHOD TO ACCESS SHIP and OTHER RESOURCES

- Visit www.shiphelp.org (click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. Refer to **Appendix A** at the back of this document for the name and contact information of the Quality Improvement Organization in your state.

The QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The QIO is an independent organization. It is not connected with our plan.

You should contact the QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

SECTION 5 Social Security

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

If you move or change your mailing address, it is important that you contact Social Security to let them know.

| Method | Social Security – Contact Information |
|----------------|--|
| CALL | 1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day. |
| TTY | 1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. |
| WEBSITE | www.ssa.gov |

If you have any questions, please call Member Services at 1-833-383-4612.

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

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

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

| Method | Railroad Retirement Board – Contact Information |
|----------------|--|
| CALL | 1-877-772-5772 Calls to this number are free. If you press “0”, you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays. |
| TTY | 1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free. |
| WEBSITE | rrb.gov/ |

SECTION 8 Do you have group insurance or other health insurance from another employer/union/trust?

Your Aetna coverage is provided through a contract with STRS Ohio. You (or your spouse or domestic

If you have any questions, please call Member Services at 1-833-383-4612.

partner) may also get medical coverage from another employer or retiree group. Call the benefits administrator if you have questions regarding coordination of your coverages. You can also call Aetna Member Services if you have any questions. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: [1-877-486-2048](tel:1-877-486-2048)) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:
Using the plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the *Schedule of Cost Sharing*. It's described in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the *Schedule of Cost Sharing*.

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

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

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

- **The care you receive is included in the plan's *Schedule of Cost Sharing*** (this chart is provided by mail).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *Provider Directory*, [STRS.AetnaMedicare.com](https://www.aetna.com/medicare).
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

If you have any questions, please call Member Services at 1-833-383-4612.

Section 2.1

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

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

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

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

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

Please refer to your *Provider Directory* or go to our website at STRS.AetnaMedicare.com for a complete listing of PCPs in your area.

What is the role of a PCP in coordinating covered services?

Your PCP will provide most of your care, and when you need more specialized services, they will coordinate your care with other providers. They will help you find a specialist and will arrange for covered services you get as a member of our plan. Some of the services that the PCP will coordinate include:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions

Coordinating your services includes consulting with other plan providers about your care and how it is progressing. Since your PCP will provide and coordinate most of your medical care, we recommend that you have your past medical records sent to your PCP's office.

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

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

How do you choose your PCP?

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

Changing your PCP

If you have any questions, please call Member Services at 1-833-383-4612.

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. Contact us immediately if your member ID card does not show the PCP you want to use. We will update your file and send you a new member ID card to reflect the change in PCP.

To change your PCP, call Member Services **before** you set up an appointment with a new PCP. When you call, be sure to tell Member Services if you are seeing specialists or currently getting other covered services that were coordinated by your PCP (such as home health services and durable medical equipment). They will check to see if the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, let you know the effective date of your change request, and answer your questions about the change.

| | |
|-------------|--|
| Section 2.2 | How to get care from specialists and other network providers |
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

What is the role of the PCP in referring members to specialists and other providers?

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

Prior authorization process

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

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

What if a specialist or another network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
 - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

If you have any questions, please call Member Services at 1-833-383-4612.

- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. A prior authorization may be required in this situation.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

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| Section 2.3 | How to get care from out-of-network providers |
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As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

If you have any questions, please call Member Services at 1-833-383-4612.

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

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| Section 3.1 | Getting care if you have a medical emergency |
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What is a medical emergency and what should you do if you have one?

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care wherever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.

Our plan covers worldwide services outside of the United States under the following circumstances:

- Emergency care
- Urgently needed care
- Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the *Schedule of Cost Sharing* for more information. Be sure to get a copy of all your medical records from your emergency or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services (phone numbers are printed on your member ID card).

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

If you have any questions, please call Member Services at 1-833-383-4612.

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

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

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

If you need to locate an urgent care facility, you can find an in-network urgent care center near you by using the *Provider Directory*, going to our website at STRS.AetnaMedicare.com, or getting help from Member Services.

Our plan covers worldwide emergency and urgent care services outside of the United States under the following circumstances:

- Emergency care
- Urgently needed care
- Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility

Transportation back to the United States from another country is not covered. Pre-scheduled and/or elective procedures are not covered. See the *Schedule of Cost Sharing* for more information. Be sure to get a copy of all your medical records from your emergency or urgent care provider before you leave; you may need them to file a claim or to help with claims processing. Without these records we may not be able to pay your claim.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: STRS.AetnaMedicare.com for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

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

If you have any questions, please call Member Services at 1-833-383-4612.

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

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

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

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

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay for services after a benefit limit has been reached do not count toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you have any questions, please call Member Services at 1-833-383-4612.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and you would pay the \$20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation, such as a provider bill, to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan, such as a provider bill.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call [1-877-486-2048](tel:1-877-486-2048).

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| SECTION 6 | Rules for getting care in a religious non-medical health care institution |
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| Section 6.1 | What is a religious non-medical health care institution? |
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If you have any questions, please call Member Services at 1-833-383-4612.

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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| Section 6.2 | Receiving Care from a Religious Non-Medical Health Care Institution |
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits may apply. See the *Schedule of Cost Sharing*.

SECTION 7 **Rules for ownership of durable medical equipment**

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| Section 7.1 | Will you own the durable medical equipment after making a certain number of payments under our plan? |
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Aetna Medicare Plan (PPO) we will transfer ownership of certain DME items. Call Member Services to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

If you have any questions, please call Member Services at 1-833-383-4612.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

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| Section 7.2 | Rules for oxygen equipment, supplies, and maintenance |
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What oxygen benefits are you entitled to?

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

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

If you leave Aetna Medicare Plan (PPO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:
*Medical Benefits Chart (what is covered and
what you pay)*

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

The plan provides a Medical Benefits Chart (*Schedule of Cost Sharing*) that lists your covered services and shows how much you will pay for each covered service as a member of Aetna Medicare Plan (PPO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 and the *Schedule of Cost Sharing* tell you more about your plan deductible.)
- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The *Schedule of Cost Sharing* tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The *Schedule of Cost Sharing* tells you more about your coinsurance.)

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

Section 1.2 What is your plan deductible?

Your deductible (if applicable) is shown in the *Schedule of Cost Sharing*. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year. The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. Refer to the *Schedule of Cost Sharing* for a full list of services that are not subject to the plan deductible.

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

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services. These amounts are shown in the *Schedule of Cost Sharing*.

- Your **in-network maximum out-of-pocket amount (MOOP)** is listed in the *Schedule of Cost Sharing*. This is the most you pay during the calendar year for covered plan services received from network providers. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services from network and out-of-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums (if applicable) do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the *Schedule of Cost Sharing*.) If you have paid the in-network maximum out-of-pocket amount listed in the *Schedule of Cost Sharing* for covered services from network and out-of-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to

If you have any questions, please call Member Services at 1-833-383-4612.

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

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

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

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| Section 1.4 | Our plan does not allow providers to balance bill you |
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As a member of Aetna Medicare Plan (PPO), an important protection for you is that after you meet any deductibles (if applicable), you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Member Services.

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

If you have any questions, please call Member Services at 1-833-383-4612.

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some of the services listed in the *Schedule of Cost Sharing* are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Aetna Medicare Plan (PPO).
 - Covered services that need approval in advance to be covered as in-network services are marked by a note in the *Schedule of Cost Sharing*.
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call [1-877-486-2048](tel:1-877-486-2048).)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Part B drugs may be subject to Step Therapy requirements. For more details, please see the **"Medicare Part B Prescription Drugs"** section in your *Schedule of Cost Sharing*.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

SECTION 3 What services are not covered by the plan?

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| Section 3.1 | Services we do <i>not</i> cover (exclusions) |
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If you have any questions, please call Member Services at 1-833-383-4612.

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|----------------------------------|---------------------------------|---|
| Acupuncture | | <ul style="list-style-type: none"> • Available for people with chronic low back pain under certain circumstances. • Additional coverage may be provided by STRS Ohio. See your <i>Schedule of Cost Sharing</i>. |
| Cosmetic surgery or procedures | | <ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance. |

If you have any questions, please call Member Services at 1-833-383-4612.

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|--|--|
| <p>Custodial care</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p> | Not covered under any condition | |
| <p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.</p> | | <ul style="list-style-type: none"> • May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. • (See Chapter 3, Section 5 for more information on clinical research studies.) |
| <p>Fees charged for care by your immediate relatives or members of your household.</p> | Not covered under any condition | |
| <p>Full-time nursing care in your home.</p> | Not covered under any condition | |
| <p>Home-delivered meals</p> | Not covered under any condition | |
| <p>Homemaker services include basic household assistance, including light housekeeping or light meal preparation.</p> | Not covered under any condition | |
| <p>Naturopath services (uses natural or alternative treatments).</p> | Not covered under any condition | |
| <p>Non-routine dental care</p> | | <ul style="list-style-type: none"> • Dental care required to treat illness or injury may be covered as inpatient or outpatient care. |

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

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|---|--|---|
| Orthopedic shoes or supportive devices for the feet | | <ul style="list-style-type: none"> Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. |
| Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television. | Not covered under any condition | |
| Private room in a hospital. | | <ul style="list-style-type: none"> Covered only when medically necessary. |
| Reversal of sterilization procedures and or non-prescription contraceptive supplies. | Not covered under any condition | |
| Routine chiropractic care | | <ul style="list-style-type: none"> Manual manipulation of the spine to correct a subluxation is covered. |
| Routine dental care, such as cleanings, fillings or dentures. | Not covered under any condition | |
| Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids. | | <ul style="list-style-type: none"> Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Additional coverage may be provided by STRS Ohio. See your <i>Schedule of Cost Sharing</i>. |
| Routine foot care | | <ul style="list-style-type: none"> Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). |

If you have any questions, please call Member Services at 1-833-383-4612.

| Services not covered by Medicare | Not covered under any condition | Covered only under specific conditions |
|--|--|---|
| Routine hearing exams, hearing aids, or exams to fit hearing aids. | | <ul style="list-style-type: none"> Some coverage may be provided by STRS Ohio. See your <i>Schedule of Cost Sharing</i>. |
| Services considered not reasonable and necessary, according to Original Medicare standards | Not covered under any condition | |

CHAPTER 5:

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

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

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

1. When you've received medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

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

- You only have to pay your cost-sharing amount when you get covered services covered by our plan. We do not allow providers to add additional separate charges, called *balance billing*. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your medical and Part B vaccine claims to us within 12 months** of the date you received the service, item, or Part B drug.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (STRS.AetnaMedicare.com) or call Member Services and ask for the form

For medical claims (including vaccines for preventing COVID-19, Flu/influenza, Pneumonia): Mail your request for payment together with any bills or paid receipts to us at this address:

Aetna Medicare
PO Box 981106
El Paso, TX 79998-1106

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

If you have any questions, please call Member Services at 1-833-383-4612.

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

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

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6: *Your rights and responsibilities*

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

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|-------------|---|
| Section 1.1 | We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.) |
|-------------|---|

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. Many documents are also available in Spanish. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialties in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services at the number on your member ID card. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY [1-800-537-7697](tel:1-800-537-7697).

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| Sección 1.1 | Debemos proporcionarle información de una manera que sea conveniente para usted y compatible con sus sensibilidades culturales (en otros idiomas además de español, en braille, en tamaño de letra grande o en otros formatos alternativos, etc.) |
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Su plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de forma culturalmente competente y sean accesibles a todos los inscritos, incluidos los que tienen un dominio limitado del inglés, una capacidad limitada de lectura, una incapacidad auditiva o un origen cultural y étnico diverso. Ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, suministro de servicios del traductor, servicios de interpretación, teletipos o TTY (teléfono o teléfono de teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder las preguntas de los miembros que no hablan inglés. Muchos documentos también están disponibles en español. También podemos proporcionarle información en braille, en tamaño de letra grande o en otros formatos alternativos, sin costo alguno, si lo necesita. Debemos proporcionarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información sobre nosotros de una manera que sea conveniente para usted, llame al Departamento de Servicios para Miembros.

If you have any questions, please call Member Services at 1-833-383-4612.

Nuestro plan está obligado a ofrecer a las mujeres inscritas la opción de acceder directamente a un especialista en salud de la mujer dentro de la red para los servicios de atención médica de rutina y preventivos para la mujer.

Si no están disponibles los proveedores de la red del plan para una especialidad, es responsabilidad del plan localizar proveedores especializados fuera de la red que le proporcionen la atención necesaria. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde puede obtener este servicio al costo compartido dentro de la red.

Si tiene alguna dificultad para obtener información sobre nuestro plan en un formato que sea accesible y adecuado para usted, llámenos para presentar una queja ante el Departamento de Servicios para Miembros (los números de teléfono están impresos en la contraportada de este documento). También puede presentar un reclamo ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles llamando al 1-800-368-1019 o al TTY [1-800-537-7697](tel:1-800-537-7697).

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for your first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically this requires that

If you have any questions, please call Member Services at 1-833-383-4612.

information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

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| Section 1.4 | We must give you information about the plan, its network of providers, and your covered services |
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As a member of Aetna Medicare Plan (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 of this document (and the *Schedule of Cost Sharing*) provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.
- **Information from interpreters.** Our plan interpreter services are available in all languages including American Sign Language. Interpreter services are available for on-site interpretation during a medical appointment. If you require these services, please contact Member Services at least two weeks in advance of your scheduled appointment.

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| Section 1.5 | We must support your right to make decisions about your care |
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You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by

If you have any questions, please call Member Services at 1-833-383-4612.

our plan.

- **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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members as well. Keep a copy at home.

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

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

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

What if your instructions are not followed?

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

If you have any questions, please call Member Services at 1-833-383-4612.

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| Section 1.6 | You have the right to make complaints and to ask us to reconsider decisions we have made |
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint — **we are required to treat you fairly.**

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| Section 1.7 | What can you do if you believe you are being treated unfairly or your rights are not being respected? |
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, gender identity, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY [1-800-537-7697](tel:1-800-537-7697), or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Member Services.**
- You can **call the State Health Insurance Assistance Program (SHIP).** For details, go to Chapter 2, Section 3 or **Appendix A** at the back of this document.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY [1-877-486-2048](tel:1-877-486-2048)).

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| Section 1.8 | How to get more information about your rights |
|-------------|---|

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

- You can **call Member Services.**
- You can **call the State Health Insurance Assistance Program (SHIP).** For details, go to Chapter 2, Section 3 or **Appendix A** at the back of this document.
- You can contact **Medicare.**
 - You can visit the Medicare website to read or download the publication Medicare Rights & Protections. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY [1-877-486-2048](tel:1-877-486-2048)).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered**

If you have any questions, please call Member Services at 1-833-383-4612.

services. Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.

- Chapters 3 and 4 (and the *Schedule of Cost Sharing*) give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums (if applicable).
 - You must continue to pay your Medicare Part B to remain a member of the plan.
 - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

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

SECTION 1 Introduction

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| Section 1.1 | What to do if you have a problem or concern |
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This chapter explains two types of processes for handling problems and concerns:

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

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

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| Section 1.2 | What about the legal terms? |
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There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in **Appendix A** at the back of this document.

Medicare

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

If you have any questions, please call Member Services at 1-833-383-4612.

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 9** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If you have any questions, please call Member Services at 1-833-383-4612.

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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| Section 4.2 | How to get help when you are asking for a coverage decision or making an appeal |
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program (SHIP).
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
 - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Member Services (phone numbers are printed on your member ID card) and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot begin or complete our

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

review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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| Section 4.3 | Which section of this chapter gives the details for your situation? |
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There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

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

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your State Health Insurance Assistance Program (SHIP).

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

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| Section 5.1 | This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care |
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This section is about your benefits for medical care. These benefits are described in the Medical Benefits Chart (*Schedule of Cost Sharing*). In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing

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facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms

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

A fast coverage decision is called an **expedited determination**.

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

A standard coverage decision is usually made within 14 calendar days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only* ask for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If the doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains that if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request for a **medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an

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answer to your complaint as soon as we make the decision. (The process for making a complaint is different than the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more calendar days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

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| Section 5.3 | Step-by-step: How to make a Level 1 appeal |
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Legal Terms

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

A fast appeal is also called an **expedited reconsideration**.

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

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may

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give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

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

Legal Term

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2

- For the fast appeal the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24**

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hours from the date we receive the decision from the review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
 - Explaining its decision.
 - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

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| Section 5.5 | What if you are asking us to pay you for our share of a bill you have received for medical care? |
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Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals

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process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

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

Within two calendar days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY [1-877-486-2048](tel:1-877-486-2048)).

1. Read this notice carefully and ask questions if you don't understand it. It tells you about:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2 You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

If you have any questions, please call Member Services at 1-833-383-4612.

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- 3 Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
- If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call [1-877-486-2048](tel:1-877-486-2048). You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices.

Section 6.2

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program (SHIP), a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

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

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Appendix A** at the back of this document.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do not meet this deadline**, contact us. If 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.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be

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discharged on that date.

- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call [1-877-486-2048](tel:1-877-486-2048).) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 6.3

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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement

If you have any questions, please call Member Services at 1-833-383-4612.

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

Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

| | |
|-------------|--|
| Section 7.1 | <i>This section is only about three services:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services |
|-------------|--|

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

If you have any questions, please call Member Services at 1-833-383-4612.

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

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Term

Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal**. Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a fast track appeal to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program (SHIP), a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

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

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

How can you contact this organization?

If you have any questions, please call Member Services at 1-833-383-4612.

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

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in **Appendix A** at the back of this document.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

| Legal Term |
|---|
| Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage. |

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4

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

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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you 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 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after our Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

If you have any questions, please call Member Services at 1-833-383-4612.

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

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

If you have any questions, please call Member Services at 1-833-383-4612.

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

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

| Complaint | Example |
|---|--|
| Quality of your medical care | <ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)? |
| Respecting your privacy | <ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information? |
| Disrespect, poor customer service, or other negative behaviors | <ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan? |
| Waiting times | <ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting or exam room. |
| Cleanliness | <ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office? |
| Information you get from us | <ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand? |

If you have any questions, please call Member Services at 1-833-383-4612.

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

| Complaint | Example |
|--|--|
| <p>Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)</p> | <p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint. |

Section 9.2 How to make a complaint

Legal Terms

- A **complaint** is also called a **grievance**.
- **Making a complaint** is also called **filing a grievance**.
- **Using the process for complaints** is also called **using the process for filing a grievance**.
- A **fast complaint** is also called an **expedited grievance**.

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly — either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- To use our grievance (complaint) process, you should call or send us your written complaint using one of the contact methods listed in Chapter 2: *Important Phone Numbers and Resources (How to contact us when you are making a complaint about your medical care)*.
 - Please be sure you provide all pertinent information, including any supporting documents you believe are appropriate. Your complaint must be received by us within 60 calendar days of the event or incident that resulted in you filing your complaint.
 - Your issue will be investigated by a member of our complaint team. If you submit your complaint verbally, we will inform you of the result of our review and our decision verbally or in writing. If you submit a verbal complaint and request your response to be in writing, we will respond in writing. If you send us a written complaint, we will send you a written response, stating the result of our review. Our notice will include a description of our understanding of

If you have any questions, please call Member Services at 1-833-383-4612.

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

your complaint and our decision in clear terms.

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

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. **Appendix A** has the contact information.

Or

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

If you have any questions, please call Member Services at 1-833-383-4612.

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

time.

| | |
|-------------|---|
| Section 9.5 | You can also tell Medicare about your complaint |
|-------------|---|

You can submit a complaint about Aetna Medicare Plan (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call [1-877-486-2048](tel:1-877-486-2048).

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Aetna Medicare Plan (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
 - As a member of the STRS Ohio group retiree plan, you may voluntarily end your membership at other times as permitted by your plan sponsor. There are also certain specific times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

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

If you are not currently entitled to Medicare Part A, you are enrolled in our plan through a special eligibility waiver. If you leave your group retiree coverage and want to join another Medicare Advantage plan, you may have to get Medicare Part A and pay an additional monthly premium.

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

Because you are enrolled in our plan through STRS Ohio, you are allowed to make plan changes at times permitted by your plan sponsor.

If STRS Ohio holds an annual Open Enrollment Period, you may be able to make a change to your health coverage at that time. STRS Ohio will let you know when your Open Enrollment Period begins and ends, what plan choices are available to you, and the effective date of coverage.

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

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|--|
| Section 2.1 Where can you get more information about when you can end your membership? |
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If you have any questions about ending your membership you can:

- **Call Member Services.**
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY [1-877-486-2048](tel:1-877-486-2048)).

If you have any questions, please call Member Services at 1-833-383-4612.

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

There are two ways you can ask to be disenrolled:

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

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

If you are not currently entitled to Medicare Part A, you are enrolled in our plan through a special eligibility waiver. If you leave your group retiree coverage and want to join another Medicare Advantage plan, you may have to get Medicare Part A and pay an additional monthly premium.

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

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

- **Continue to use our network provider to receive medical care.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new healthy coverage begins).

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

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|---|
| Section 5.1 When must we end your membership in the plan? |
|---|

Aetna Medicare Plan (PPO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

If you have any questions, please call Member Services at 1-833-383-4612.

- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Aetna Medicare Plan (PPO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY [1-877-486-2048](tel:1-877-486-2048)).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9: *Legal notices*

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY [1-800-537-7697](tel:1-800-537-7697)) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.hhs.gov/ocr/index.html.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

In some situations, other parties should pay for your medical care before your Medicare Advantage health plan. In those situations, your Medicare Advantage plan may pay, but have the right to get the payments back from these other parties. Medicare Advantage plans may not be the primary payer for medical care you receive. These situations include those in which the Federal Medicare Program is considered a secondary payer under the Medicare Secondary Payer laws. For information on the Federal Medicare Secondary Payer program, Medicare has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First* (publication number 02179). You can get a copy by calling 1-800-MEDICARE, 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

The Plan's rights to recover in these situations are based on the terms of this health plan contract, as well as the provisions of the federal statutes governing the Medicare Program. Your Medicare Advantage plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers' compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical

If you have any questions, please call Member Services at 1-833-383-4612.

- payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
 - Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

Since your Medicare Advantage plan is always secondary to any automobile no-fault (Personal Injury Protection) or medical payments coverage, you should review your automobile insurance policies to ensure that appropriate policy provisions have been selected to make your automobile coverage primary for your medical treatment arising from an automobile accident.

As outlined herein, in these situations, your Medicare Advantage plan may make payments on your behalf for this medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your Medicare Advantage plan shall be subrogated to stand in the place of all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

In addition, if you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your Medicare Advantage plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your Medicare Advantage plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your Medicare Advantage plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. Your Medicare Advantage plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your Medicare Advantage plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Medicare Advantage plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan's efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your

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Medicare Advantage plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

Failure to provide requested information or failure to assist your Medicare Advantage plan in pursuit of its subrogation or recovery rights may result in you being personally responsible for reimbursing the plan for benefits paid relating to the injury, illness or condition as well as for the plan's reasonable attorney fees and costs incurred in obtaining reimbursement from you. For more information, see 42 U.S.C. § 1395y(b)(2)(A)(ii) and the Medicare statutes.

SECTION 4 Notice about recovery of overpayments

If the benefits paid by this *Evidence of Coverage*, plus the benefits paid by other plans, exceeds the total amount of expenses, Aetna has the right to recover the amount of that excess payment from among one or more of the following: (1) any person to or for whom such payments were made; (2) other Plans; or (3) any other entity to which such payments were made. This right of recovery will be exercised at Aetna's discretion. You shall execute any documents and cooperate with Aetna to secure its right to recover such overpayments, upon request by Aetna.

SECTION 5 National Coverage Determinations

Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2025, either Medicare or our plan will cover those services. When we receive coverage updates from Medicare, called National Coverage Determinations, we'll post the coverage updates on our website at [STRS.AetnaMedicare.com](https://www.strs.aetna.com). You can also call Member Services to obtain the coverage updates that have been posted for the benefit year.

CHAPTER 10:
Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Aetna Medicare Plan (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to balance bill or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

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

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

Complaint – The formal name for making a complaint is filing a grievance. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan’s monthly premium, if applicable.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed copayment amount that a plan requires when a specific service is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service that a plan requires when a specific service is received.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who don’t have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

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

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

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

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

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Aetna also offers Medicare Advantage plans to members of employer group retiree plans who do not have Part A coverage.

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

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

Network – A group of doctors, hospitals, pharmacies, and other health care experts contracted by our plan to provide covered services to its members (see Chapter 1, Section 3.2). Network providers are independent contractors and not agents of our plan.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

Non-Medicare Covered Services – Services that are not normally covered when you have Original Medicare. These are usually extra benefits you may receive as a member of a Medicare Advantage plan.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for Cost Sharing above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

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

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you, or if you are a member of our plan through STRS Ohio group retiree plan.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contract. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

APPENDIX A:

Important contact information

| Quality Improvement Organizations (QIO) | |
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| <p>Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont</p> | <p>Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-319-8452, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, Website: acentraqio.com</p> |
| <p>Region 2: New Jersey, New York, Puerto Rico, Virgin Islands</p> | <p>Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-866-815-5440, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, Website: livantaqio.cms.gov/en</p> |
| <p>Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia</p> | <p>Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-396-4646, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, Website: livantaqio.cms.gov/en</p> |
| <p>Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee</p> | <p>Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-317-0751, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, Website: acentraqio.com</p> |
| <p>Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin</p> | <p>Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-524-9900, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, Website: livantaqio.cms.gov/en</p> |
| <p>Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas</p> | <p>Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-315-0636, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, Website: acentraqio.com</p> |
| <p>Region 7: Iowa, Kansas, Missouri, Nebraska</p> | <p>Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-888-755-5580, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, Website: livantaqio.cms.gov/en</p> |
| <p>Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming</p> | <p>Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-317-0891, TTY: 711, Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, Website: acentraqio.com</p> |

Appendix A. Important contact information

| Quality Improvement Organizations (QIO) | |
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| Region 9: American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands | Livanta, Address: Livanta LLC – BFCC-QIO, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105, Phone: 1-877-588-1123, American Samoa (684) 699-3330, Guam (671) 685-2689, Northern Mariana Islands (670) 989-2686, TTY: 711 , Hours: Monday–Friday 9:00 AM to 5:00 PM, Saturday–Sunday/Holidays 10:00 AM to 4:00 PM local time, Website: livantaqio.cms.gov/en |
| Region 10: Alaska, Idaho, Oregon, Washington | Acentra Health, Address: 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609, Phone: 1-888-305-6759, TTY: 711 , Hours: Monday–Friday 9:00 AM to 5:00 PM, Weekends and holidays 10:00 AM to 4:00 PM, Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time, Website: acentraqio.com |

| State Medicaid Office | |
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| AK | Alaska Medicaid, Address: Alaska Department of Health, Division of Public Assistance, PO Box 110640, 350 Main Street, Room 304, Juneau, AK 99811-0640, Phone: 1-800-780-9972 (coverage or billing), 1-800-478-7778 (eligibility), TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx |
| AL | Alabama Medicaid Agency, Address: Central Office, 501 Dexter Avenue, Montgomery, Alabama 36104, Phone: 1-800-362-1504, 334-242-5000, TTY: 1-800-253-0799 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: medicaid.alabama.gov/ |
| AR | Arkansas Medicaid, Address: Arkansas Department of Human Services, PO Box 1437, Slot S401, Little Rock, AR 72203-1437, Phone: 1-800-482-8988, 1-800-482-5431, TTY: 501-682-8933 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: humanservices.arkansas.gov/divisions-shared-services/medical-services/ |
| AS | American Samoa Medicaid State Agency, Address: PO Box 998383, Pago Pago, AS 96799, Phone: 684-699-4777, 684-699-4778, TTY: 711 , Hours: Monday-Friday 8:00 AM-5:00 PM, Website: medicaid.as.gov |
| AZ | Arizona Health Care Cost Containment System (AHCCCS), Address: Office of Individual and Family Affairs (OIFA), 801 E. Jefferson Street, Phoenix, AZ 85034, Phone: 1-800-654-8713, 602-417-4000, TTY: 1-800-842-6520 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 7:00 AM to 9:00 PM, Saturday 8:00 AM to 6:00 PM, Website: azahcccs.gov/ |
| CA | Medi-Cal (California’s Medicaid program), Address: California Department of Health Care Services, 1501 Capitol Avenue, Sacramento, CA 95814, Phone: 1-800-541-5555, 916-552-9200, TTY: 1-800-430-7077 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhcs.ca.gov/services/medi-cal/Pages/default.aspx |
| CO | Health First Colorado, Address: Colorado Department of Health Care, Policy & Financing, 303 E. 17th Avenue, Denver, CO 80203, Phone: 1-800-221-3943, TTY: 711 , Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: healthfirstcolorado.com/ |

If you have any questions, please call Member Services at 1-833-383-4612.

| | State Medicaid Office |
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| CT | HUSKY Health (Connecticut's Medicaid program), Address: HUSKY Health Program, c/o Department of Social Services, 55 Farmington Ave., Hartford, CT 06105-3724, Phone: General Information: 1-877-284-8759, Member Services 1-800-859-9889, TTY: 1-866-492-5276 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: General Information: Monday–Friday 7:30 AM to 4:00 PM, Member Services: Monday–Friday 8:00 AM to 6:00 PM, Website: portal.ct.gov/HUSKY/Welcome |
| DC | DC Medicaid, Address: The Department of Health Care Finance – DHCF, 441 4th Street NW, 900S, Washington, DC 20001, Phone: 202-442-5988, TTY: 711 , Hours: Monday–Friday 8:15 AM to 4:45 PM, Website: dhcf.dc.gov/service/medicaid |
| DE | Delaware Medicaid, Address: Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DMMA), 1901 N. DuPont Highway, New Castle, DE 19720, Phone: 1-866-843-7212, 302-571-4900, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhss.delaware.gov/dhss/dmma/medicaid.html |
| FL | Florida Division of Medicaid, Address: Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308, Phone: 1-877-711-3662, 850-412-4000, TTY: 1-866-467-4970 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Thursday, 8:00 AM to 8:00 PM, Friday 8:00 AM to 7:00 PM, Website: ahca.myflorida.com/medicaid |
| GA | Georgia Medicaid, Address: The Department of Community Health (DCH), 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334, Phone: Toll Free: 1-877-423-4746, Customer Service: (404) 657-5468, Eligibility: 404-651-9982, Member Services: 866-211-0950, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.georgia.gov/ |
| GU | Guam Medicaid, Address: Department of Public Health & Social Services, 761 South Marine Corps Drive, Tamuning, GU 96913, Phone: 671-300-7330, TTY: 711 , Hours: 8:00 AM to 4:00 PM, Website: dphss.guam.gov |
| HI | Hawaii Med-QUEST (Quality, Universal Access, Efficiency, Sustainability, Transformation), Address: Department of Human Services, 1350 S. King Street, Suite 200, Honolulu, HI 96814, Phone: 808-524-3370 (Oahu), 1-800-316-8005 (Neighbor Islands), TTY: 711 , Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: medquest.hawaii.gov/ |
| IA | Iowa Medicaid, Address: Iowa Department of Health and Human Services, 1305 E Walnut Street, Des Moines, IA 50319-0114, Phone: 1-800-338-8366, 515-256-4606, TTY: 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.iowa.gov/programs/welcome-iowa-medicaid |
| ID | Idaho Medicaid, Address: Idaho Department of Health and Welfare, PO Box 83720, Boise, ID 83720-0036, Phone: 1-888-528-5861, 1-877-456-1233, TTY: 1-888-791-3004 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: healthandwelfare.idaho.gov/services-programs/medicaid-health |
| IL | Illinois Medicaid, Address: Department of Healthcare and Family Services (HFS), Prescott Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763, Phone: 1-800-843-6154, 1-866-468-7543, TTY: 1-877-204-1012 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hfs.illinois.gov/about/about.html |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Medicaid Office | |
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| IN | Indiana Medicaid, Address: Family and Social Services Administration, 402 W. Washington Street, Room W392, PO Box 7083, Indianapolis, IN 46204, Phone: 1-800-403-0864, 1-800-457-4584, TTY: 711 , Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/fssa/ompp/ |
| KS | KanCare (Kansas’ Medicaid program), Address: KanCare Clearinghouse, PO Box 3599, Topeka, KS 66601, Phone: 1-800-792-4884, TTY: 711 or 1-800-792-4292 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kancare.ks.gov/ |
| KY | Kentucky Medicaid, Address: Cabinet for Health and Family Services (CHFS), 275 E. Main St., Frankfort, KY 40621, Phone: Member Services: 1-800-635-2570, Eligibility: 1-855-306-8959, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dms/Pages/default.aspx |
| LA | Louisiana Medicaid, Address: Louisiana Department of Health, PO Box 629, Baton Rouge, LA 70821-0629, Phone: 1-888-342-6207, TTY: 1-855-526-3346 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: ldh.la.gov/page/about-medicaid |
| MA | MassHealth (Massachusetts’ Medicaid program), Address: One Ashburton Place, Boston, MA 02108, Phone: 1-800-841-2900, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mass.gov/orgs/masshealth |
| MD | Maryland Medicaid, Address: Department of Health, Herbert R. O’Conor State Office Building, 201 W. Preston Street, Baltimore, MD 21201-2399, Phone: 1-877-463-3464, 410-767-6500, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: mmcp.health.maryland.gov/Pages/home.aspx |
| ME | MaineCare, Address: Department of Health and Human Services, Office for Family Independence, 114 Corn Shop Lane, Farmington, ME 04938, Phone: 1-800-977-6740, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: maine.gov/dhhs/ofi/programs-services/health-care-assistance |
| MI | Michigan Medicaid, Address: Health & Human Services, 333 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, Phone: 1-800-642-3195, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: michigan.gov/medicaid |
| MN | Medical Assistance (MA) (Minnesota’s Medicaid program), Address: Department of Human Services, 540 Cedar Street, Saint Paul, MN 55101, Phone: 1-800-657-3739, 651-431-2670, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp |
| MO | Missouri Medicaid (MO HealthNet), Address: Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, Phone: 573-751-3425, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mydss.mo.gov/mhd |
| MP | Northern Mariana Islands Medical Assistance for the Needy (MAN) Program, Address: Commonwealth Medicaid Agency, Government Building No. 1252, Capitol Hill Rd., Caller Box 10007 Saipan MP 96950, Phone: 670-664-4880/82/86/87/88 (Eligibility), 670-664-4883/84 (Claims), TTY: 711 , Hours: Monday–Thursday 7:30 AM to 1:00 PM, Closed on Fridays and holidays, Website: http://medicaid.cnmi.mp/ |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Medicaid Office | |
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| MS | Mississippi Division of Medicaid, Address: MS Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201, Phone: 1-800-421-2408, 601-359-6050, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.ms.gov/ |
| MT | Montana Medicaid, Address: Department of Public Health and Human Services (DPHHS), 111 North Sanders Street, Helena, MT 59601-4520, PO Box 4210, Helena, MT 59604-4210, Phone: 1-800-362-8312 (Member Help Line), 1-888-706-1535 (Eligibility), TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices |
| NC | NC Medicaid, Division of Health Benefits, Address: 2501 Mail Service Center, Raleigh, NC 27699-2501, Phone: 1-888-245-0179, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.ncdhhs.gov/ |
| ND | North Dakota Medicaid, Address: Medical Services Division, North Dakota Health and Human Services, 600 E. Boulevard Ave., Dept. 325, Bismarck, ND 58505-0250, Phone: 1-800-755-2604, 701-328-7068, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.nd.gov/healthcare/medicaid |
| NE | Nebraska Medicaid, Address: Department of Health and Human Services, 301 Centennial Mall South, Lincoln, NE 68509, Phone: 1-855-632-7633 (Eligibility), 402-471-3121 (Division of Medicaid), TTY: 1-402-471-7256 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx |
| NH | New Hampshire Medicaid (Medical Assistance) program, Address: Department of Health & Human Services, Division of Medicaid Services, 129 Pleasant Street, Concord, NH 03301, Phone: 1-844-275-3447, TTY: 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: dhhs.nh.gov/programs-services/medicaid |
| NJ | NJ Department of Human Services, Division of Medical Assistance & Health Services, Address: NJ Department of Human Services, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, Phone: 1-800-701-0710, TTY: 711 , Hours: Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM, Website: state.nj.us/humanservices/dmahs/ |
| NM | Centennial Care (New Mexico’s Medicaid program), Address: Human Services Department, PO Box 2348, Santa Fe, NM 87504-2348, Phone: 1-800-283-4465, TTY: 711 , Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: hsd.state.nm.us/lookingforassistance/centennial-care-overview/ |
| NV | Nevada Medicaid, Address: Department of Health and Human Services, PO Box 30042, Reno, NV 89520-3042, Phone: 1-877-638-3472, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicaid.nv.gov |
| NY | New York State Medicaid, Address: New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237, Phone: 1-800-541-2831, TTY: 711 , Hours: Monday–Friday 8:00 AM to 8:00 PM, Saturday 9:00 AM to 1:00 PM, Website: health.ny.gov/health_care/medicaid/ |
| OH | Ohio Medicaid, Address: Ohio Department of Medicaid, 50 W. Town Street, Suite 400, Columbus, OH 43215, Phone: 1-800-324-8680, TTY: 711 , Hours: Monday–Friday 7:00 AM to 8:00 PM, Saturday 8:00 AM to 4:00 PM, Website: medicaid.ohio.gov/ |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Medicaid Office | |
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| OK | SoonerCare, Address: Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, Phone: 1-800-987-7767, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oklahoma.gov/ohca.html |
| OR | Oregon Health Plan (OHP), Address: PO Box 14015, Salem, OR 97309, Phone: 1-800-273-0557, TTY: 711 , Hours: Monday–Friday 7:00 AM to 6:00 PM, Website: oregon.gov/oha/hsd/ohp/Pages/index.aspx |
| PA | Medical Assistance (Pennsylvania’s Medicaid program), Address: Department of Human Services, County Assistance Office (CAO), 801 Market Street, Philadelphia, PA 19107, Phone: 1-215-560-7226, TTY: 711 or 1-800-451-5886 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx |
| PR | Medicaid Program, Address: Department Of Health, PO Box 70184, San Juan, PR 00936-8184, Phone: 787-641-4224, TTY: 787-625-6955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: medicaid.pr.gov |
| RI | Rhode Island Executive Office of Health and Human Services (EOHHS), Address: PO Box 8709, Cranston, RI 02920-8787, Phone: 1-855-697-4347, TTY: 711 , Hours: Monday–Friday 8:30 AM to 4:00 PM, Website: eohhs.ri.gov/consumer/health-care |
| SC | Healthy Connections (South Carolina’s Medicaid program), Address: Department of Health and Human Services (SCDHHS), PO Box 8206, Columbia, SC 29202-8206, Phone: 1-888-549-0820, TTY: 1-888-842-3620 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: scdhhs.gov/ |
| SD | South Dakota Medicaid, Address: Department of Social Services, 700 Governors Drive, Pierre, SD 57501, Phone: 1-800-597-1603, 605-773-3165, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dss.sd.gov/medicaid/ |
| TN | TennCare Medicaid (Tennessee’s Medicaid program), Address: 310 Great Circle Road, Nashville, TN 37243, Phone: 1-855-259-0701 (Applications), 1-800-342-3145 (General), TTY: 1-877-779-3103 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 7:00 AM to 6:00 PM, Website: tn.gov/tenncare |
| TX | Texas Medicaid Program, Address: Health and Human Services (HHS), North Austin Complex, 4601 W. Guadalupe St., Austin, TX 78751-3146, PO Box 13247, Austin, Texas 78711-3247, Phone: 1-800-252-8263, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/medicaid-chip |
| UT | Utah Medicaid, Address: Department of Health and Human Services, Cannon Health Building, 288 North 1460 West, Salt Lake City, UT 84116, Phone: 1-800-662-9651, 801-538-6155 (Customer Service); 801-526-0950, 1-866-435-7414 (Eligibility), TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM MST (Tuesday hours are 11:00 AM to 5:00 PM), Website: medicaid.utah.gov/ |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Medicaid Office | |
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| VA | Virginia Medicaid, Address: Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, Phone: 1-855-242-8282, 804-786-7933 (Customer Service); 1-833-522-5582 (Enrollment), TTY: 1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 7:00 PM and Saturday 9:00 AM to 12:00 PM, Website: dmas.virginia.gov/ |
| VI | Virgin Islands Medicaid Program, Address: Department of Human Services, Knud Hansen Complex 1303 Hospital Ground Bldg. A, St. Thomas, VI 00802; 3011 Golden Rock, Christiansted, St. Croix, VI 00820, Phone: 340-715-6929 (Customer Support), 340-774-0930 (St. Thomas/St. John), 340-772-7100 (St. Croix), TTY: 711 , Hours: Monday–Friday 7:00 AM to 7:00 PM, Website: vimmis.com/default.aspx |
| VT | Vermont Medicaid Programs, Address: Agency of Human Services, Department of Vermont Health Access, 280 State Drive, Waterbury, VT 05671-1500, Phone: 1-800-250-8427, TTY: 711 , Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: dvha.vermont.gov/members |
| WA | Washington Apple Health, Address: Health Care Authority, Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501, Phone: 1-800-562-3022, TTY: 711 , Hours: Monday–Friday 7:00 AM to 5:00 PM, Website: hca.wa.gov/ |
| WI | Wisconsin Medicaid, Address: Department of Health Services, 1 West Wilson Street, Madison, WI 53703, Phone: 1-800-362-3002, 608-266-1865, TTY: 711 or 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 6:00 PM, Website: dhs.wisconsin.gov/medicaid/index.htm |
| WV | West Virginia Medicaid program, Address: Department of Health and Human Resources, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3709, Phone: 1-877-716-1212, 304-558-1700, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: dhhr.wv.gov/bms/Pages/default.aspx |
| WY | Wyoming Medicaid, Address: Wyoming Department of Health, Healthcare Financing Division, 122 W. 25th St., 4th Floor West, Cheyenne, WY 82002, Phone: 1-855-294-2127, 307-777-7531, TTY: 1-855-329-5204 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: health.wyo.gov/ |

| State Health Insurance Assistance Program (SHIP) | |
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| AK | Alaska Medicare Information Office, Address: Department of Health, 1835 Bragaw Street, Suite 350, Anchorage, AK 99508, Phone: 1-800-478-6065, 907-269-3680, TTY: 1-800-770-8973 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: medicare.alaska.gov |
| AL | Alabama State Health Insurance Assistance Program, Address: RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, Phone: 1-877-425-2243, 334-242-5743, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: alabamaageline.gov/ship/ |
| AR | Arkansas Seniors Health Insurance Information Program (AR SHIIP), Address: 1 Commerce Way, Little Rock, AR 72202, Phone: 1-800-224-6330, TTY: 501-683-4468 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: shiipar.com |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Health Insurance Assistance Program (SHIP) | |
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| AZ | Arizona State Health Insurance Assistance Program, Address: Department of Economic Security, Division of Aging and Adult Services, 1789 W. Jefferson Street, Phoenix, AZ 85007, Phone: 1-800-432-4040, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: des.az.gov/medicare-assistance |
| CA | California Health Insurance Counseling and Advocacy Program (HICAP), Address: Department of Aging, 2880 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, Phone: 1-800-434-0222, TTY: 1-800-735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.ca.gov/hicap/ |
| CO | Colorado Senior Health Care & Medicare Assistance (SHIP & SMP), Address: Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202, Phone: 1-888-696-7213, 1-800-503-5190, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare |
| CT | Connecticut’s Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES), Address: Department of Aging and Disability Services, 55 Farmington Ave., 12th Floor, Hartford, CT 06105, Phone: 1-800-994-9422, TTY: 860-247-0775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: portal.ct.gov/ADS-CHOICES |
| DC | Health Insurance Counseling Project (HICP), Address: Department of Aging and Community Living, 250 E Street SW, Washington, DC 20024, Phone: 202-727-8370, TTY: 711 , Hours: Monday–Friday 9:30 AM to 4:30 PM, Website: dacl.dc.gov/service/health-insurance-counseling |
| DE | Delaware Medicare Assistance Bureau (DMAB), Address: Department of Insurance, 1351 West North Street, Suite 101, Dover, DE 19904, Phone: 1-800-336-9500, 302-674-7364, TTY: 711 , Hours: Monday–Friday 8:30 AM to 3:30 PM, Website: insurance.delaware.gov/divisions/dmab/ |
| FL | Serving Health Insurance Needs of Elders (SHINE) (Florida SHIP), Address: Department of Elder Affairs, 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000, Phone: 1-800-963-5337, TTY: 1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: floridashine.org/ |
| GA | Georgia SHIP, Address: Department of Human Services, Division of Aging Services, 229 Peachtree Street NE, Suite 100, Atlanta, GA 30303, Phone: 1-866-552-4464, Option 4, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.georgia.gov/georgia-ship |
| GU | Guam State Health Insurance Assistance Program (SHIP), Address: Department of Public Health and Social Services, Division of Senior Citizens, Guam Department of Public Health and Social Services, 123 Chalan Kareta, Mangilao, Guam 96913-6304, Phone: 671-735-7415, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphss.guam.gov |
| HI | Hawaii SHIP, Address: State Department of Health, Executive Office on Aging, No. 1 Capitol District, 250 South Hotel Street, Suite 406, Honolulu, HI 96813-2831, Phone: 1-888-875-9229, 808-586-7299, TTY: 1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 7:45 AM to 4:30 PM, Website: hawaiiiship.org/ |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Health Insurance Assistance Program (SHIP) | |
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| IA | Iowa Senior Health Insurance Information Program (SHIIP), Address: Insurance Division, 1963 Bell Ave., Suite 100, Des Moines, IA 50315, Phone: 1-800-351-4664, TTY: 1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: shiip.iowa.gov/ |
| ID | Idaho Senior Health Insurance Benefits Advisors (SHIBA), Address: Department of Insurance, 700 W. State Street, 3rd Floor, PO Box 83720, Boise, ID 83720-0043, Phone: 1-800-247-4422, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, except state holidays, Website: doi.idaho.gov/SHIBA/ |
| IL | Senior Health Insurance Program (Illinois SHIP), Address: Department on Aging, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271, Phone: 1-800-252-8966, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: www2.illinois.gov/aging/ship/Pages/default.aspx |
| IN | Indiana State Health Insurance Assistance Program, Address: Department of Insurance, 311 W. Washington Street, Indianapolis, IN 46204, Phone: 1-800-452-4800, TTY: 1-866-846-0139 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: in.gov/ship/ |
| KS | Senior Health Insurance Counseling for Kansas (SHICK), Address: Department for Aging and Disability Services, New England Building, 503 S. Kansas Ave., Topeka, KS 66603-3404, Phone: 1-800-860-5260, TTY: 785-291-3167 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick |
| KY | Kentucky State Health Insurance Assistance Program, Address: Cabinet for Health and Family Services, 275 E. Main Street, 3E-E, Frankfort, KY 40601, Phone: 1-877-293-7447 (Option 2), 502-564-6930, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: chfs.ky.gov/agencies/dail/Pages/ship.aspx |
| LA | Louisiana Senior Health Insurance Information Program (SHIIP), Address: Department of Insurance, 1702 N. Third Street, PO Box 94214, Baton Rouge, LA 70802, Phone: 1-800-259-5300, Option 2, 225-342-5301, TTY: 711 , Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: ldi.la.gov/consumers/senior-health-shiip |
| MA | SHINE (Serving Health Insurance Needs of Everyone) (Massachusetts SHIP), Address: Executive Office of Elder Affairs, 1 Ashburton Place, 3rd Floor, Boston, MA 02108, Phone: 1-800-243-4636, TTY: 1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 9:00 AM to 5:00 PM, Website: mass.gov/health-insurance-counseling |
| MD | Maryland State Health Insurance Assistance Program, Address: Department of Aging, 301 West Preston Street, Suite 1007, Baltimore, MD 21201, Phone: 1-800-243-3425, 410-767-1100, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.maryland.gov/Pages/state-health-insurance-program.aspx |
| ME | Maine State Health Insurance Assistance Program, Address: Department of Health and Human Services, Office of Aging and Disability Services, 11 State House Station, 41 Anthony Avenue, Augusta, ME 04333, Phone: 1-800-262-2232, 207-287-9200, TTY: 711 , Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Health Insurance Assistance Program (SHIP) | |
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| MI | Michigan Medicare Assistance Program (MMAP), Address: Department of Health & Human Services, 333 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, Phone: 1-800-803-7174, 1-800-975-7630, TTY: 1-888-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 7:00 PM, Website: mmapinc.org/ |
| MN | Minnesota’s Senior LinkAge Line, Address: Elmer L. Anderson Human Services, 540 Cedar Street, St. Paul, MN 55164, Phone: 1-800-333-2433, TTY: 1-800-627-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00AM to 4:30 PM, Website: mn.gov/senior-linkage-line/ |
| MO | Missouri SHIP, Address: Department of Commerce & Insurance, 301 West High St., Room 530, PO Box 690, Jefferson City, MO 65102, Phone: 1-800-390-3330, TTY: 711 , Hours: Monday–Friday 9:00 AM to 4:00 PM, Website: missouriship.org |
| MS | Mississippi State Health Insurance Assistance Program (SHIP), Address: Department of Human Services, Division of Aging and Adult Services, 200 South Lamar St., Jackson, MS 39201, Phone: 1-844-822-4622, 601-709-0624, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: mdhs.ms.gov/aging/finding-services-for-older-adults/ |
| MT | Montana State Health Insurance Assistance Program (SHIP), Address: Department of Public Health and Human Services, Senior and Long Term Care Division, 1100 N Last Chance Gulch, 4th Floor, Helena MT 59601, Phone: 1-800-551-3191, 406-444-4077, TTY: 1-800-833-8503 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: dphhs.mt.gov/sltc/aging/ship |
| NC | Medicare and Seniors’ Health Insurance Information Program (SHIIP) (North Carolina SHIP), Address: Department of Insurance, 3200 Beechleaf Court, Raleigh NC 27604, Phone: 1-855-408-1212, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip |
| ND | North Dakota State Health Insurance Assistance Program (SHIP), Address: Insurance Department, 600 E. Boulevard Ave., 5th Floor, Bismarck, ND 58505-0320, Phone: 1-888-575-6611, 1-800-233-1737, TTY: 1-800-366-6888 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Thursday 8:00 AM to 5:00 PM, Friday 8:00 AM to 12:00 PM, Website: insurance.nd.gov/shic-medicare |
| NE | Nebraska SHIP, Address: Department of Insurance, 1526 K Street, Suite 201, Lincoln, NE 68508, Phone: 1-800-234-7119, TTY: 1-800-833-7352 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: doi.nebraska.gov/ship-smp |
| NH | ServiceLink (New Hampshire SHIP), Address: Department of Health & Human Services, Brown Building, 129 Pleasant Street, Concord, NH 03301, Phone: 1-866-634-9412, TTY: 1-800-735-2964 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: servicelink.nh.gov |
| NJ | New Jersey State Health Insurance Assistance Program (SHIP), Address: State Health Insurance Assistance Program, PO Box 807, Trenton, NJ 08625, Phone: 1-800-792-8820, TTY: 711 , Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: nj.gov/humanservices/doas/services/q-z/ship/index.shtml |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Health Insurance Assistance Program (SHIP) | |
|---|--|
| NM | New Mexico State Health Insurance Assistance Program (SHIP), Address: New Mexico Aging & Long-Term Services Department, 2550 Cerrillos Road, Santa Fe, NM 87505, Phone: 1-800-432-2080, TTY: 505-476-4937 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:00 PM, Website: aging.nm.gov |
| NV | Nevada State Health Insurance Assistance Program (SHIP), Address: Department of Health & Human Services, Aging and Disability Services Division, 3416 Goni Road, Suite D-132, Carson City, NV 89706, Phone: 1-800-307-4444, TTY: 711 , Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_%28MAP%29/MAP_Prog/ |
| NY | Health Insurance Information, Counseling and Assistance (HIICAP), Address: 2 Empire State Plaza, 5th Floor, Albany, NY 12223, Phone: 1-800-701-0501, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: aging.ny.gov/health-insurance-information-counseling-and-assistance |
| OH | Ohio Senior Health Insurance Information Program (OSHIIP), Address: Department of Insurance, 50 W. Town Street, Third Floor, Suite 300, Columbus, OH 43215, Phone: 1-800-686-1578, 614-644-2658, TTY: 711 , Hours: Monday–Friday 7:30 AM to 5:00 PM, Website: insurance.ohio.gov/about-us/divisions/oshiip |
| OK | Oklahoma Senior Health Insurance Counseling Program (SHIP), Address: Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105, Phone: 1-800-763-2828, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oid.ok.gov/consumers/information-for-seniors/ |
| OR | Oregon Senior Health Insurance Benefits Assistance (SHIBA), Address: Department of Human Services, 500 Summer St. NE, E-12, Salem, Oregon 97301, Phone: 1-800-722-4134, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: shiba.oregon.gov/ |
| PA | Pennsylvania Medicare Education and Decision Insight (PA MEDI), Address: Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919, Phone: 1-800-783-7067, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx |
| PR | Programa Estatal de Asistencia Sobre Seguros de Salud (SHIP: State Health Insurance Assistance Program), Address: Oficina del Procurador de las Personas de Edad Avanzada, Oficina Central, Avenida Ponce de León, Parada 16 Edificio 1064 tercer piso, Santurce (altos del edificio de Marshalls), San Juan, PR 00919-1179, Phone: 1-800-981-0056 (Mayaguez); 1-800-981-7735 (Ponce); 1-877-725-4300 (Saint John), TTY: 787-919-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx |
| RI | Rhode Island State Health Insurance Assistance Program (SHIP), Address: Office of Healthy Aging, 25 Howard Ave., Building 57, Cranston, RI 02920, Phone: 1-888-884-8721, TTY: 401-462-0740 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: oha.ri.gov/Medicare |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Health Insurance Assistance Program (SHIP) | |
|---|--|
| SC | Insurance Counseling Assistance and Referrals for Elders (I-Care) Program (South Carolina SHIP), Address: Department on Aging, 1301 Gervais Street, Suite 350, Columbia, SC 29201, Phone: 1-800-868-9095, TTY: 1-888-842-3620 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: getcaresc.com/guide/insurance-counseling-medicaremedicaid |
| SD | Senior Health Information and Insurance Education (SHIINE) (South Dakota SHIP), Address: Department of Human Services, Division of Long Term Services and Support, 3800 E Hwy 34 - Hillsvie Plaza, c/o 500 E. Capitol Avenue, Pierre, SD 57501, Phone: 1-800-536-8197 (Eastern SD), 1-877-331-4834 (Central SD), 1-877-286-9072 (Western SD), TTY: 711 , Hours: Monday–Friday 9:00 AM to 4:30 PM, Website: dhs.sd.gov/en/understand-my-medicare |
| TN | Tennessee State Health Insurance Assistance Program (SHIP), Address: Commission on Aging and Disability, Andrew Jackson Bldg., 9th Floor, 502 Deaderick Street, Nashville, TN 37243, Phone: 1-877-801-0044, TTY: 1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: tnmedicarehelp.com/ |
| TX | Texas Health Information, Counseling and Advocacy Program (HICAP), Address: Texas Health and Human Services Commission, Mail Code W358, PO Box 149030, Austin, Texas 78714-9030, Phone: 1-800-252-9240, 1-855-937-2372, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: hhs.texas.gov/services/health/medicare |
| UT | Utah Senior Health Insurance Information Program (SHIP), Address: Department of Health & Human Services, Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah 84116, Phone: 1-800-541-7735, TTY: 711 , Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: daas.utah.gov/seniors/ |
| VA | Virginia Insurance Counseling and Assistance Program (VICAP), Address: Division for Aging Services, 1610 Forest Ave., Suite 100, Henrico, VA 23229, Phone: 1-800-552-3402, 804-662-9333, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: vda.virginia.gov/vicap.htm |
| VI | Virgin Islands State Health Insurance Assistance Program (VISHIP), Address: Office of the Lieutenant Governor, 1131 King Street, Suite 101, Christiansted, St. Croix, Virgin Islands 00820 (St. Croix); 5049 Kongens Gade, St. Thomas, Virgin Islands 00802 (St. Thomas/St. John), Phone: 340-773-6449 (St. Croix), 340-774-2991 (St. Thomas/St. John), TTY: 711 , Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: https://ltg.gov.vi/departments/vi-ship-medicare/ |
| VT | Vermont State Health Insurance Assistance Program (SHIP), Address: Department of Disabilities, Aging and Independent Living, Adult Services Division, 280 State Drive, HC2 South, Waterbury, VT 05671-2070, Phone: 1-800-642-5119, TTY: 711 , Hours: Monday–Friday 8:30 AM to 4:30 PM, Website: asd.vermont.gov/services/ship |
| WA | Washington Statewide Health Insurance Benefits Advisors (SHIBA), Address: Office of the Insurance Commissioner, PO Box 40255, Olympia, WA 98504-0255, Phone: 1-800-562-6900, TTY: 360-586-0241 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 5:00 PM, Website: insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba |

If you have any questions, please call Member Services at 1-833-383-4612.

| State Health Insurance Assistance Program (SHIP) | |
|---|---|
| WI | Wisconsin State Health Insurance Assistance Program (SHIP), Address: Department of Health Services, 1 W. Wilson Street, Madison, WI 53703, Phone: 1-800-242-1060, TTY: 711 or 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking, Hours: Monday–Friday 8:00 AM to 4:30 PM, Website: dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm |
| WV | West Virginia State Health Insurance Assistance Program (WV SHIP), Address: Bureau of Senior Services, 1900 Kanawha Blvd. East, (3rd Floor Town Center Mall) Charleston, WV 25305, Phone: 1-877-987-4463, 304-558-3317, TTY: 711 , Hours: Monday–Friday 8:30 AM to 5:00 PM, Website: wvship.org/ |
| WY | Wyoming State Health Insurance Information Program (WSHIP), Address: 106 W. Adams Ave., Riverton, WY 82501, Phone: 1-800-856-4398, TTY: 711 , Hours: Monday–Friday 7:00 AM to 4:00 PM, Website: wyomingseniors.com/ |

If you have any questions, please call Member Services at 1-833-383-4612.

APPENDIX B:

*Aetna Medicare Plan (PPO) Service Areas**

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

Below is a list of counties within the Aetna Medicare Plan (PPO) service area. Your plan sponsor may not offer coverage in each of these counties. If you are moving to a new service area, you should contact your former employer to ask what coverage options may be available to you.

Appendix B: Aetna PPO

| |
|---|
| Alabama |
| Barbour • Chambers • Dale • Henry • Houston • Macon • Mobile • Russell |
| Arizona |
| Graham • La Paz • Maricopa • Mohave • Pima • Pinal • Santa Cruz • Yavapai • Yuma |
| California |
| Fresno • Los Angeles • Orange • Riverside • San Bernardino • San Diego • San Francisco • Ventura |
| Colorado |
| Adams • Arapahoe • Boulder • Broomfield • Denver • Douglas • El Paso • Jefferson • Larimer • Weld |
| Connecticut |
| Fairfield • Hartford • Litchfield • Middlesex • New Haven • New London • Tolland • Windham |
| Delaware |
| Kent • New Castle • Sussex |
| District of Columbia |
| Washington DC |
| Florida |
| Bradford • Brevard • Broward • Charlotte • Citrus • Clay • Collier • DeSoto • Duval • Flagler • Hernando • Highlands • Hillsborough • Indian River • Lake • Lee • Manatee • Marion • Martin • Miami-Dade • Nassau • Orange • Osceola • Palm Beach • Pasco • Pinellas • Polk • Sarasota • Seminole • St. Johns • St. Lucie • Volusia |

Georgia

Appling • Baldwin • Banks • Barrow • Bartow • Ben Hill • Bibb • Bleckley • Bryan • Burke • Butts • Camden • Carroll • Catoosa • Charlton • Chatham • Chattahoochee • Cherokee • Clarke • Clayton • Clinch • Cobb • Coffee • Columbia • Coweta • Crawford • Crisp • Dawson • DeKalb • Dooly • Dougherty • Douglas • Echols • Effingham • Elbert • Emanuel • Evans • Fannin • Fayette • Floyd • Forsyth • Franklin • Fulton • Gilmer • Glynn • Gordon • Greene • Gwinnett • Habersham • Hall • Hancock • Haralson • Harris • Hart • Heard • Henry • Houston • Irwin • Jackson • Jasper • Johnson • Jones • Lamar • Laurens • Lee • Liberty • Lincoln • Long • Lumpkin • Madison • Marion • McDuffie • McIntosh • Meriwether • Monroe • Morgan • Murray • Muscogee • Newton • Oconee • Oglethorpe • Paulding • Peach • Pickens • Pike • Polk • Putnam • Quitman • Rabun • Randolph • Richmond • Rockdale • Schley • Spalding • Stephens • Stewart • Sumter • Talbot • Taliaferro • Tattnall • Taylor • Terrell • Tift • Toombs • Towns • Treutlen • Troup • Turner • Twiggs • Union • Upson • Walton • Warren • Washington • Wayne • White • Worth

Idaho

Ada • Canyon

Illinois

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

Indiana

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

Iowa

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

Kansas

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

Kentucky

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

Louisiana

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

| |
|--|
| Maine |
| Androscoggin • Aroostook • Cumberland • Franklin • Hancock • Kennebec • Knox • Lincoln • Oxford • Penobscot • Piscataquis • Sagadahoc • Somerset • Waldo • York |
| Maryland |
| Allegany • Anne Arundel • Baltimore • Baltimore City • Calvert • Caroline • Carroll • Cecil • Charles • Dorchester • Frederick • Garrett • Harford • Howard • Kent • Montgomery • Prince George's • Queen Anne's • St. Mary's • Talbot • Washington • Wicomico • Worcester |
| Massachusetts |
| Bristol • Essex • Hampden • Middlesex • Norfolk • Plymouth • Suffolk • Worcester |
| Michigan |
| Allegan • Antrim • Arenac • Bay • Benzie • Berrien • Branch • Calhoun • Cass • Clare • Genesee • Gladwin • Grand Traverse • Gratiot • Hillsdale • Jackson • Kalamazoo • Kalkaska • Kent • Lapeer • Leelanau • Livingston • Macomb • Midland • Missaukee • Monroe • Muskegon • Newaygo • Oakland • Oceana • Ogemaw • Otsego • Ottawa • Roscommon • Saginaw • Sanilac • Shiawassee • St. Clair • St. Joseph • Tuscola • Washtenaw • Wayne • Wexford |
| Mississippi |
| Benton • Calhoun • Chickasaw • Clay • DeSoto • Panola • Pontotoc • Prentiss • Tippah • Tunica • Webster |
| Missouri |
| Benton • Boone • Buchanan • Cass • Christian • Clay • Cole • Crawford • Dade • Dallas • Franklin • Greene • Henry • Hickory • Jackson • Jasper • Jefferson • Johnson • Lawrence • Lincoln • Platte • Polk • Ray • St. Charles • St. Louis • St. Louis City • Stone • Warren • Washington • Webster • Wright |
| Nebraska |
| Dodge • Douglas • Lancaster • Sarpy • Washington |
| Nevada |
| Carson City • Clark • Washoe |
| New Hampshire |
| Belknap • Hillsborough • Merrimack • Rockingham • Strafford |
| New Jersey |
| Atlantic • Bergen • Burlington • Camden • Cape May • Cumberland • Essex • Gloucester • Hudson • Hunterdon • Mercer • Middlesex • Monmouth • Morris • Ocean • Passaic • Salem • Somerset • Sussex • Union • Warren |
| New Mexico |
| Bernalillo • Cibola • Sandoval • Socorro • Torrance • Valencia |
| New York |
| Albany • Bronx • Broome • Cayuga • Chemung • Chenango • Columbia • Cortland • Delaware • Dutchess • Genesee • Greene • Jefferson • Kings • Lewis • Livingston • Madison • Monroe • Nassau • New York • Oneida • Onondaga • Ontario • Orange • Orleans • Oswego • Putnam • Queens • Rensselaer • Richmond • Rockland • Saratoga • Schenectady • Schuyler • Seneca • St. Lawrence • Steuben • Suffolk • Sullivan • Tioga • Tompkins • Ulster • Wayne • Westchester • Yates |

North Carolina

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

Ohio

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

Oklahoma

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

Pennsylvania

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

Rhode Island

Bristol • Kent • Newport • Providence • Washington

South Carolina

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

Tennessee

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

Texas

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

Utah

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

Virginia

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

Washington

King • Kitsap • Mason • Pierce • Snohomish • Thurston

West Virginia

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

Wisconsin

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

Multi-Language Insert Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-282-0631. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-282-0631. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-282-0631。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-282-0631。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-282-0631. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-282-0631. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-282-0631. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-282-0631. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-282-0631. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-282-0631. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-282-0631. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-282-0631 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-282-0631. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-282-0631. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-282-0631. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-282-0631. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-866-282-0631. にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele 'ōlelo kā mākou i mea e pane 'ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā'au lapa'au paha. I mea e loa'a ai ke kōkua māhele 'ōlelo, e kelepona mai iā mākou ma 1-866-282-0631. E hiki ana i kekahi mea 'ōlelo Pelekānia/'Ōlelo ke kōkua iā 'oe. He pōmaika'i manuahi kēia.

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

Aetna Medicare Plan (PPO) Member Services

| Method | Member Services – Contact Information |
|----------------|---|
| CALL | Please call 1-833-383-4612 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers. |
| TTY | 711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. |
| WRITE | Aetna Medicare PO Box 7082 London, KY 40742 |
| WEBSITE | STRS.AetnaMedicare.com |

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **Appendix A** at the back of this document.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*