January 1 – December 31, 2026

Evidence of Coverage for 2026:

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

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

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

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at the telephone number on your member ID card or 1-888-267-2637. (TTY users call 711). Hours are 8 AM to 9 PM ET, Monday through Friday. This call is free.

This plan, Aetna Medicare Plan (HMO), 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 (HMO).)

This document is available for free in Spanish. Este documento está disponible de forma gratuita 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 copayment/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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OMB Approval 0938-1051 (Expires: August 31, 2026)
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Table of Contents

CHAPTER 1:
Get started as a member

SECTION 1 You're a member of Aetna Medicare Plan (HMO)

Section 1.1 You're enrolled in Aetna Medicare Plan (HMO), which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Aetna Medicare Plan (HMO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Aetna Medicare Plan (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Aetna Medicare Plan (HMO) doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Aetna Medicare Plan (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you get 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 the months you're enrolled in Aetna Medicare Plan (HMO) between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Aetna Medicare Plan (HMO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Aetna Medicare Plan (HMO) each year. Your former employer/union/trust can continue to offer you Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States
- You meet the eligibility requirements of your former employer/union/trust

Section 2.2 Plan service area for Aetna Medicare Plan (HMO)

Aetna Medicare Plan (HMO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is descibed in **Appendix B** at the back of this document.

If you move out of our plan's service area, you will have a Special Enrollment Period that will allow you to switch to a different plan. Please contact your former employer/union/trust plan administrator to see what other plan options are available in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

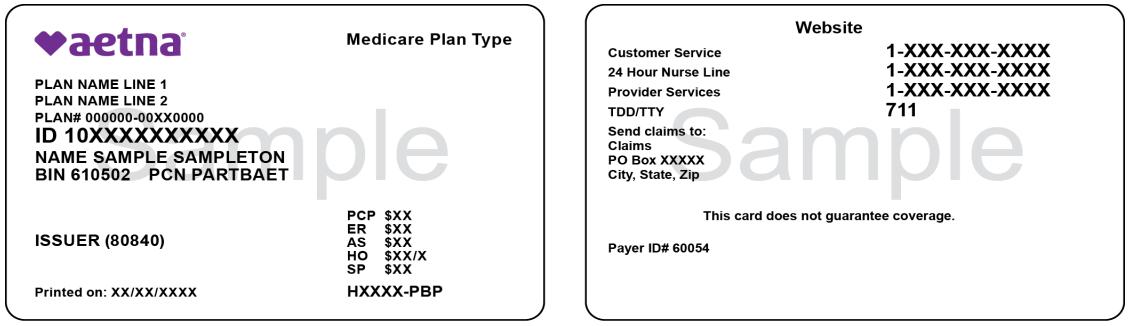
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Aetna Medicare Plan (HMO) if you're not eligible to stay a member of our plan on this basis. Aetna Medicare Plan (HMO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Aetna Medicare Plan (HMO) 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 our plan membership card is damaged, lost, or stolen, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* **AetnaRetireePlans.com** 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'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Aetna Medicare Plan (HMO) authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers on our website at **AetnaRetireePlans.com**.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call

711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2026

For the details on what medical care is covered by our plan and how much you pay when you get this care, go to the *Schedule of Cost Sharing*.

Your costs may include the following:

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

Section 4.1 Plan premium

As a member of our plan, you may pay a monthly plan premium. Please contact your plan benefits administrator for information about your plan premium (if applicable).

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website at **medicare.gov/medicare-and-you** or order a printed copy by phone at 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

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, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay our plan premium

For most members, your plan benefits administrator will provide you with information about our plan premium (if applicable). If Aetna bills you directly for your total plan premium, we'll mail you a **monthly invoice** detailing your premium amount.

For members who have an Aetna plan premium and are billed directly by Aetna, there are 4 ways you can pay our plan premium. You may inform us of your premium payment option choice or change your choice by calling Member Services.

Option 1: Pay by check
If you did not select a payment option on our enrollment application at the time you enrolled in our plan, we will automatically set you up on the **invoice method** so that you can make your payments by check. You may decide to pay your monthly plan premium to us by check using our invoice method. Please make your checks payable to our plan (which is indicated on your invoice) not to CMS nor HHS. Monthly plan premium payments are due the 1st day of each month for coverage of the current month. We must receive your check and corresponding month's invoice slip in our office by the 10th of each month to prevent your account from becoming delinquent. All monthly plan premium payments should be sent to the address listed on your payment invoice.

You will receive your first invoice within 45 days of your coverage effective date. You will then receive it every month going forward if a balance is owed. Be sure to include your invoice slip with your check to

ensure the appropriate credit is applied to your account. In the event that you need a replacement invoice or you wish to change your payment method, please call Member Services for assistance.

Option 2: Paying at a CVS Pharmacy
If a barcode is printed on your invoice, you may pay your monthly plan premium at any retail CVS location (excluding CVS pharmacies in Target and Schnucks stores). You can do this by taking your invoice and having it rung up at the register like any prescription or item you are purchasing. The CVS associate will ask you how much you would like to pay toward your premium and you will need to confirm the amount on the credit/debit card machine. You will then be able to pay the premium along with any other items you are purchasing with cash or credit/debit cards.

You do not need to fill a prescription or use CVS Pharmacies for any of your prescriptions in order to take advantage of this payment method. You do not need to sign up for any CVS loyalty programs to use this payment method. A unique barcode is assigned to each member so you may not use another person's invoice to pay your bill. This payment method is only available to members with a barcode printed on their monthly invoice. If you have any questions about this payment method, please contact Member Services and not CVS associates.

Option 3: Paying by automatic withdrawal
You may decide to pay your monthly plan premium by an automatic payment from your checking/savings account or credit/debit card by the Electronic Fund Transfer (EFT) option.

- To enroll in this program online, go to **AetnaMedicare.com/PayBill**. Select the following deduction options: "on due date" and "amount due".
- Alternatively, you may contact Member Services or complete and return the authorization form located on your premium invoice. Your plan premium will be automatically deducted from your bank account between the 10th and the 15th of each month unless it is a weekend or bank holiday, then the deduction will occur the next business day. By selecting this payment option, you will no longer receive an invoice.

Option 4: Using your credit/debit card or via e-check
You may pay your plan premium each month by using your credit/debit card or checking account. Please remember all premiums are due on the first of the month.

- Pay each month or set up a recurring payment selecting your choice of withdrawal date and amount online at **AetnaMedicare.com/PayBill**.
- You may also call Member Services to make a payment over the phone. You will continue to receive an invoice if you set up this payment option.

Changing the way you pay your plan premium
If you decide to change how you pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're responsible for making sure that your plan premium is paid on time. To change your payment method, please contact Member Services.

If you have trouble paying your plan premium
If you have trouble paying your plan premium on time, please contact Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) to see if we can direct you to programs that will help with your costs.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you prior to the date our plan renews and the change will take effect on the date our plan renews.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone 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 our plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

SECTION 7 How other insurance works with our plan

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 a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first, is called ("the primary payer"), pays up to the limits of its coverage. The insurance 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 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) are 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are 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 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.

CHAPTER 2:
Phone numbers and resources

SECTION 1 Aetna Medicare Plan (HMO) contacts

For help with claims, billing, or member card questions, call or write to Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711). We'll be happy to help you.

Member Services – Contact Information	
Call	Please call the telephone number on your member ID card or 1-888-267-2637 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711) 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 14089 Lexington, KY 40512
Website	AetnaRetireePlans.com

How to ask 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 pay for your medical services . An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care , go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	Please call the telephone number on your member ID card or 1-888-267-2637 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	AetnaRetireePlans.com

Appeals for Medical Care – Contact Information	
Call	Please call the telephone number on your member ID card or **1-888-267-2637** 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	**AetnaRetireePlans.com**

How to make 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	Please call the telephone number on your member ID card or **1-888-267-2637** 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	To submit a complaint about Aetna Medicare Plan (HMO) directly to Medicare, go to **www.Medicare.gov/my/medicare-complaint**.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests for Medical Coverage – Contact Information	
Fax	1-866-474-4040

Payment Requests for Medical Coverage – Contact Information	
Write	Aetna Medicare PO Box 981106 El Paso, TX 79998-1106
Website	AetnaRetireePlans.com

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	PO Box 1270, Lawrence, KS 66044 • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit PO Box 1270, Lawrence, KS 66044 to tell Medicare about any complaints you have with Aetna Medicare Plan (HMO). **To submit a complaint to Medicare**, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

SHIP is an independent state program (not connected with any insurance company or health plan) 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, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare 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 Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It's not connected with our plan.

You should contact the Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you have got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures or misdiagnosis.
- 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 is ending too soon.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. If you move or change your mailing address, contact Social Security to let them know.

Social Security – Contact Information	
Call	**1-800-772-1213** Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. 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 am to 7 pm, Monday through Friday.
Website	**SSA.gov**

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. Medicaid offers programs to 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 Medicare Savings 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 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	**1-877-772-5772** Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number aren't free.
Website	**https://RRB.gov/**

SECTION 8 If you have group insurance or other health insurance from an employer

Your Aetna coverage is provided through a contract with your former employer/union/trust. You (or your spouse or domestic 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 at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) with any questions. You can call 1-800-MEDICARE (**1-800-633-4227**) with questions about your Medicare coverage under this plan. TTY users call **1-877-486-2048**.

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

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the *Schedule of Cost Sharing* in Chapter 4.

Section 1.1 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 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 your medical care to be covered by our plan

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

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

- **The care you get is included in our plan's *Schedule of Cost Sharing*** (This chart may be available by mail).
- **The care you get 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 have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3 .
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2 .
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. *Here are 3 exceptions*:
    - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3 .
    - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Prior authorization should be obtained from the plan prior to seeking care. In this situation, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4 .

- Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, you cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must 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 must have a network PCP on file** with us. It is very important that you choose a network PCP and tell us who you have chosen. Your PCP can help you stay healthy, treat illnesses, and coordinate your care with other health care providers. Your PCP (or PCP office) will appear on your member ID card. If your member ID card does not show a PCP (or PCP office) or the PCP on your card is not the one you want to use, please contact us immediately. If you use a PCP whose name (or office name) is not printed on your member ID card, you may incur a higher cost share or your claims may be denied.

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 **AetnaRetireePlans.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. Certain types of covered services may require a referral from your PCP.

What is the role of the PCP in making decisions about or getting 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"). Getting 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 to choose a PCP
You can select your PCP by using the *Provider Directory*, by accessing our website at **AetnaRetireePlans.com**, or getting help from Member Services. If you have not selected a PCP, a PCP will be assigned to you. You can change your PCP for any reason, and at any time by contacting Member Services.

If there is a particular plan specialist or hospital that you want to use, check first to be sure that your PCP makes referrals to that specialist, or uses that hospital.

How to change your PCP
You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose 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.

They will also send you a new membership card that shows the name and/or phone number of your new PCP.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- Behavioral health services as long as you get them from network providers. To access behavioral health services, call the number on your member ID card.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- 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?
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. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). If you see a specialist without a referral, you may incur a higher cost share or your claims may be denied. For more details about which services require a referral from your PCP, please contact us.

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"). Getting 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*.

When a specialist or another network provider leaves our plan
It's important that you know that we may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. A prior authorization may be required in this situation.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

Section 2.4 How to get care from out-of-network providers

As a member of our plan, you must use network providers. If you receive unauthorized care from an out-of-network provider, we may deny coverage and you will be responsible for the entire cost. *Here are three exceptions:*

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.

- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider and you will pay the same as you would pay if you got the care from a network provider. You should get prior authorization from the plan prior to seeking care. Your PCP or other network provider will contact us to obtain authorization for you to see an out-of-network provider.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

You should ask the out-of-network provider to bill us first. If you have already paid for the covered services or if the out-of-network provider sends you a bill that you think we should pay, please contact Member Services or send us the bill. See Chapter 5 for information on how to ask us to pay you back or to pay a bill you have received.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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're 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's 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.

- **As soon as possible, make sure 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. Call Member Services (phone numbers are printed on your member ID card).

Covered services in 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.

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. You may have to pay the provider at the time of service and submit for reimbursement.

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

After the emergency is over, you're 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 your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. 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, aren't considered urgently needed even if you're outside our plan's service area or our 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 **AetnaRetireePlans.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 Get 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're still entitled to care from our plan.

Visit **AetnaRetireePlans.com** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Aetna Medicare Plan (HMO) covers all medically necessary services as listed in the *Schedule of Cost Sharing.* If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're 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 use 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 Medical services 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 ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved clinical research study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're 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'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in a Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays 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'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial*: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

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

Get more information about joining a clinical research study
Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at **www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf**. You can also call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

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

Section 6.1 A religious non-medical health care institution

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

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility or your stay won't be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

As a member of Aetna Medicare Plan (HMO) we will transfer ownership of certain DME items. In Original Medicare, there's a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the purchase price is met, you can use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up.

Call member services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) to find out about the requirements you must meet and the documentation you'll need to provide.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?
If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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 don't count. You'll 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare again. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage, Aetna Medicare Plan (HMO) 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 (HMO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?
Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's 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 pay for each covered service as a member of Aetna Medicare Plan (HMO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible:** the amount you must pay for your medical services before our plan begins to pay its share. (Section 1.2 and the *Schedule of Cost Sharing* tell you more about our plan deductible.)
- **Copayment:** the fixed amount you pay each time you get 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:** 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 don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan deductible

Your deductible (if applicable) is shown in the *Schedule of Cost Sharing*. Until you've paid the deductible amount, you must pay the full cost of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services and you'll pay your share. The deductible does not apply to some services. This means that we 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's the most you'll pay for covered medical services?

Medicare Advantage Plans have limits on the total amount you pay out-of-pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026, the MOOP amount is showing in the *Schedule of Cost Sharing*.**

The amounts you pay for deductibles (if applicable), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amount you pay for plan premium doesn't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the *Schedule of Cost Sharing.* If you reach the maximum out-of-pocket amount, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay our plan premium (if applicable) and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers aren't allowed to balance bill you

As a member of Aetna Medicare Plan (HMO), you have an important protection because 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 can't bill you for 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's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get 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. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or outside the service area for urgently needed services.)
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**).

SECTION 2 The *Schedule of Cost Sharing* shows your medical benefits and costs

The *Schedule of Cost Sharing* lists the services Aetna Medicare Plan (HMO) covers and what you pay out-of-pocket for each service. The services listed in the *Schedule of Cost Sharing* are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B 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 can't 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.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- Some services listed in the *Schedule of Cost Sharing* are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked by a note in the *Schedule of Cost Sharing*.

Other important things to know about our coverage:

- 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*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at **Medicare.gov** or ask for a copy by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.
- Part B drugs may be subject to Step Therapy requirements. For more details, please see the **"Medicare Part B Drugs"** section in your *Schedule of Cost Sharing*.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

SECTION 3 Services that aren't covered by our plan (exclusions)

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

The chart below lists services and items that either aren't 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 get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't 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 made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	• Available for people with chronic low back pain under certain circumstances. • Additional coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing*.
Cosmetic surgery or procedures	• 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.

Services not covered by Medicare	Covered only under specific conditions
Custodial care Custodial care is personal care that doesn't 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.	Not covered under any condition.
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. • (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition.
Full-time nursing care in your home	Not covered under any condition.
Home-delivered meals	• Some coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing*.
Homemaker services include basic household help, including light housekeeping or light meal preparation	• Some coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing*.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition.
Non-routine dental care	• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	• 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. • Additional coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing*.
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.

Services not covered by Medicare	Covered only under specific conditions
Private room in a hospital	• Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition.
Routine chiropractic care	• Manual manipulation of the spine to correct a subluxation is covered. • Additional coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing*.
Routine dental care, such as cleanings, fillings or dentures	• Coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing.*
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	• One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. • Additional coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing.*
Routine foot care	• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). • Additional coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing*.
Routine hearing exams, hearing aids, or exams to fit hearing aids	• Some coverage may be provided by your former employer/union/trust. See your *Schedule of Cost Sharing.*
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 for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to 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 got for more than your share of cost sharing. First try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**
   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're 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 pay the entire amount yourself at the time you get 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 made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. **When a network provider sends you a bill you think you shouldn't pay**
   Network providers should always bill our 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 don't 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's a dispute and we don't pay certain provider charges.
   - Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
   - If you already paid a bill to a network provider, but you feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. **If you're retroactively enrolled in our plan**
   Sometimes a person's enrollment in our 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 need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask 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've 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 got the service, item, or Part B drug.

To make sure you're 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'll help us process the information faster. The form requires you to provide information such as: name, address, Aetna ID number, provider name, provider NPI (national provider identifier), provider TIN (taxpayer identification number), provider address, date of service, reimbursement type, description of service(s), and charge(s).
- Download a copy of the form from our website (**AetnaRetireePlans.com**) or call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) 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'll consider your request for payment and say yes or no

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

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

Section 3.1 If we tell you that we won't pay for all or part of the medical care, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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, braille, large print, or other alternate formats, etc.)

Our 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 our plan may meet these accessibility requirements include, but aren't 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're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**).

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at the number on your member ID card. You can 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**.

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.).

Nuestro 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. Entre los ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad se incluyen, entre otros, proveer servicios de traducción, 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. También podemos brindarle información en otros idiomas además de inglés, incluido español y braille, en letra grande u otros formatos alternativos, sin costo alguno si lo necesita. Tenemos la obligación de brindarle información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener información nuestra de una manera que

sea conveniente para usted, llame a Servicios para Miembros al the telephone number on your member ID card or **1-888-267-2637** (los usuarios de TTY deben llamar al **711**).

Nuestro plan está obligado a brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para las mujeres.

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

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, para consultar a un especialista en salud de la mujer o para encontrar un especialista de la red, llame para presentar una queja ante el Servicio para Miembros al the telephone number on your member ID card or **1-888-267-2637** (los usuarios de TTY deben llamar al **711**). 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, si es usuario de TTY, al **1-800-537-7697**.

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

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from the plan's network of 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 you aren't 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 you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.

- Because you're a member of our plan through Medicare, we're 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 information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others
You have the right to look at your medical records held by our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

You have the right to make recommendations regarding our organizations member rights and responsibilities policy.

If you have questions or concerns about the privacy of your personal health information, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**).

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

As a member of Aetna Medicare Plan (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**):

- **Information about our plan.** This includes, for example, information about our 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 isn't 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.

Section 1.5 You have the right to know your treatment options and participate in decisions about your 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by 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. 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's to be done if you can't 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're in this situation. This means *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.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** 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. Keep a copy at home.

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

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

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

If your instructions aren't followed
If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can 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.

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

If you have any problems, concerns, or complaints and need to ask for 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're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY users call **1-800-537-7697**), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711).**
- **Call your local State Health Insurance Assistance Program (SHIP).** For details, go to Chapter 2, Section 3 or **Appendix A** at the back of this document.
- **Call Medicare** at 1-800-MEDICARE (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711).**
- **Call your local State Health Insurance Assistance Program (SHIP)**. For details, go to Chapter 2, Section 3 or **Appendix A** at the back of this document.
- **Contact Medicare**.
  - Visit **Medicare.gov** to read the publication *Medicare Rights & Protections*. (available at: **www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf**.)
  - Call 1-800-MEDICARE (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. If you have any questions, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 (and the *Schedule of Cost Sharing*) give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get 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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs,

vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
    - You must pay our plan premiums (if applicable).
    - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
    - For some of your medical services covered by our 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* our plan service area, you can't remain a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:
If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 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 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 information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

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're having. They can also answer 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 for help:

- Call 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.
- Visit **www.medicare.gov**

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.
Go to **Section 4, A guide to coverage decisions and appeals.**

No.
Go to **Section 9**, **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 coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B 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 before you get services
If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got 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'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal 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 we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You don't 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 don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

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

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call us at Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711).**
- **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 need to be appointed as your representative. Call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) 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 drugs, your doctor can ask for 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.** 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 at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) 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**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7**: 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 information applies to you, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**). You can also get help or information from your

State Health Insurance Assistance Program (SHIP).

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

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in the Medical Benefits Chart (*Schedule of Cost Sharing*). In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2**.
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2**.
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3**.
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**.
5. You're told that coverage for certain medical care you've 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 facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms

A coverage decision that involves your medical care 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 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, 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. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll 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 asked for.

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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Medicare Part B drug, we'll give you an answer within 72 hours after we get 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms
An appeal to our 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're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll 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.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're 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 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 asking for 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 the information. We check to see if we followed all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - 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'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request 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 asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll 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 asked for,** 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 Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

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

The **independent review organization is an independent organization hired by Medicare.** It isn't connected with us and isn't 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'll 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 about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give

you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

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

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

- **If the independent 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 get the decision from the independent review organization for standard requests. For expedited requests, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests,** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't 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 that:
  - Explains the decision.
  - Lets you know about your 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.
  - Tells 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 3 additional levels in the appeals process after Level 2 (for a total of 5 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 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got 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're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed 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 the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll 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 won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care

and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't 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 process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

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

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

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're 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'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**) (TTY users call **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 get 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're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got 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 got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you 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 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in **Appendix A** at the back of this document.

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 aren't 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 got (*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 can 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 don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll 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 discharged on that date.

- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) or 1-800-MEDICARE (**1-800-633-4227**). (TTY users call **1-877-486-2048**.) Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll 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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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 independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to Level 2 of the appeals process.

Section 6.3 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 its 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 Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital

after the date 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 the information about 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 its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent 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 want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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

When you're 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's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

Section 7.1 We'll tell you in advance when your coverage will be ending

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask 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 got it.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 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'll 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, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**). Or call your State Health Insurance Assistance Program (SHIP). SHIP contact information is available in **Appendix A** at the back of this document.

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 aren't 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?

- The written notice you got *(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 want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage.* The name address, and phone number of the Quality Improvement Organization for your state may also be found in **Appendix A** at the back of this document.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that gives 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll 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 its 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's medically necessary.**
- You'll 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 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, **you'll 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 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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 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 the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's

medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent 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 want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 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 your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4, and 5

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

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's 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's 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 we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll 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 the decision that turns down your appeal, the appeals process is over.
  - If you don't 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'll 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 getting the Council's decision.
  - If we decide to appeal the decision, we'll 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 don't want to accept the decision, you may 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 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 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?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions about coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't 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 called a **grievance.**
Making a complaint is called **filing a grievance.**
Using the process for complaints is called **using the process for filing a grievance.**
A **fast complaint** is called an **expedited grievance.**

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

- **Calling Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711) is usually the first step**. If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll 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 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'll 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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 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** at the back of this document has the contact information.

Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Aetna Medicare Plan (HMO) directly to Medicare. To submit a complaint to Medicare, go to **www.Medicare.gov/my/medicare-complaint**. You can also call 1-800-MEDICARE (**1-800-633-4227**). TTY/TDD users call **1-877-486-2048**.

CHAPTER 8:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

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

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

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

It's important that you carefully consider your decision to disenroll from our plan PRIOR to disenrolling. Since disenrollment from our plan could affect your former employer/union/trust health benefits, you could permanently lose your former employer/union/trust health coverage. If you're considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

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

Because you're enrolled in our plan through your former employer/union/trust, you're allowed to make plan changes at times permitted by your plan sponsor.

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

All members have the opportunity to leave the plan during the Annual Enrollment Period (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 your former employer/union/trust's group retiree plan), you're eligible to end your membership at any time through a Special Enrollment Period.

Section 2.1 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at the telephone number on your member ID card or 1-888-267-2637 (TTY users call 711).**
- Find the information in the ***Medicare & You 2026*** handbook.
- Call **Medicare** at 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

SECTION 3 How to end your membership in our plan

There are 2 ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) if you need more information on how to do

this.
- —*or*— you can contact your benefits administrator.

It's important that you carefully consider your decision to disenroll from our plan PRIOR to disenrolling. Since disenrollment from our plan could affect your former employer/union/trust health benefits, you could permanently lose your former employer/union/trust health coverage. If you're considering disenrolling from our plan and have not done so already, please consult with your plan benefits administrator.

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 starts, you must continue to get your medical items and services through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Aetna Medicare Plan (HMO) must end our plan membership in certain situations

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

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
  - If you move or take a long trip, call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership call Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Aetna Medicare Plan (HMO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.

Section 5.2 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* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call us at Member Services at the telephone number on your member ID card or **1-888-267-2637** (TTY users call **711**). 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 isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Aetna Medicare Plan (HMO), 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 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 (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week. Or you can download a copy by visiting the Medicare website (**Medicare.gov**).

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 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 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 2026, 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 **AetnaRetireePlans.com**. You can also call Member Services to obtain the coverage updates that have been posted for the benefit year.

CHAPTER 10:
Definitions

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 doesn't 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 got. You may also make an appeal if you disagree with our decision to stop services that you are getting.

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 (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to balance bill or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten 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.

Calendar Year – A one year period between January 1 and December 31.

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.

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 about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't 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 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's 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 don't 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're 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 does not involve coverage or payment disputes.

Health Maintenance Organization (HMO) – A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

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

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. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get 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) – An IPA, or Independent Practice Association, is an independent group of physicians and other health care providers under contract to provide services to members of managed care organizations (go to Chapter 1, Section 6).

Initial Enrollment Period – When you’re 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.

Low Income Subsidy (LIS) – Go to Extra Help.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.4 for information about your maximum out-of-pocket amount.

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.

Medical Group – A Medical Group is a group of physicians and other health care providers under contract to provide services to members of our plan.

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**.

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 the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't 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 our 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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 (go to 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 2 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 doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to 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.

Out-of-Pocket Threshold – The maximum amount you pay out-of-pocket for covered Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) 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 get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium, if applicable, for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

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

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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 based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart (*Schedule of Cost Sharing*).

Prosthetics and Orthotics – Medical devices including, but 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 inpatient rehabilitation care, physical therapy (outpatient), 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. Our plan must disenroll you if you permanently move out of our 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, if we violate our contract with you, or if you are a member of our plan through your former employer/union/trust group retiree plan.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed (if included in your 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

APPENDIX A:
Important contact information

	Quality Improvement Organizations (QIO)
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	**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
Region 2: New Jersey, New York, Puerto Rico, Virgin Islands	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **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
Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **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
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	**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
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **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
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	**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
Region 7: Iowa, Kansas, Missouri, Nebraska	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **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
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	**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
Region 9: Arizona, California, Hawaii, Nevada, Northern Mariana Islands	**Livanta**, **Address:** BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450, **Phone:** 1-877-588-1123, **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
Alabama	**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/
Alaska	**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
American Samoa	**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
Arizona	**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/
Arkansas	**Arkansas Medicaid**, **Address:** Arkansas Department of Human Services, PO Box 1437, Slot S401, Little Rock, AR 72203-1437, **Phone:** 1-855-372-1084, 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 7:00 AM to 7:00 PM, **Website:** humanservices.arkansas.gov/divisions-shared-services/medical-services/
California	**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 5:00 PM, **Website:** dhcs.ca.gov/services/medi-cal/Pages/default.aspx
Colorado	**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, third Thursday of each month 8:00 AM to 2:00 PM, **Website:** healthfirstcolorado.com/
Connecticut	**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
Delaware	**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:** 1-855-889-4325 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:** dhss.delaware.gov/dhss/dmma/medicaid.html

	State Medicaid Office
District of Columbia	**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
Florida	**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
Georgia	**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/
Guam	**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
Hawaii	**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/
Idaho	**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
Illinois	**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
Indiana	**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:** 1-800-743-3333 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/fssa/ompp/
Iowa	**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

	State Medicaid Office
Kansas	**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/
Kentucky	**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 4:30 PM, **Website:** chfs.ky.gov/agencies/dms/Pages/default.aspx
Louisiana	**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
Maine	**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
Maryland	**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
Massachusetts	**MassHealth (Massachusetts' Medicaid program)**, **Address:** 100 Hancock St. 1st Floor Quincy, MA 02171, **Phone:** 1-800-841-2900, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** mass.gov/orgs/masshealth
Michigan	**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
Minnesota	**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 4:00 PM, **Website:** mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Mississippi	**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/
Missouri	**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
Montana	**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

	State Medicaid Office
Nebraska	**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
Nevada	**Nevada Medicaid**, **Address:** Department of Health and Human Services, PO Box 30042, Reno, NV 89520-3042, **Phone:** 1-877-638-3472, 775-684-3600, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dhcfp.nv.gov/Members/Home/
New Hampshire	**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
New Jersey	**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/
New Mexico	**Turquoise Care (New Mexico's Medicaid program)**, **Address:** New Mexico Health Care Authority, PO Box 2348, Santa Fe, NM 87504-2348, **Phone:** 1-800-283-4465, **TTY:** 711, **Hours:** Monday–Friday 7:00 AM to 6:30 PM, **Website:** hsd.state.nm.us/turquoise-care/
New York	**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:** 1-800-662-1220 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 8:00 PM, Saturday 9:00 AM to 1:00 PM, **Website:** health.ny.gov/health_care/medicaid/
North Carolina	**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/
North Dakota	**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
Northern Mariana Islands	**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, 670-664-4882, 670-664-4886, 670-664-4887, 670-664-4888 (Eligibility), 670-664-4883, 670-664-4884 (Claims), **TTY:** 711, **Hours:** Monday–Thursday 7:30 AM to 1:00 PM, Closed on Fridays and holidays, **Website:** medicaid.cnmi.mp/

	State Medicaid Office
Ohio	**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 5:00 PM, **Website:** medicaid.ohio.gov/
Oklahoma	**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
Oregon	**Oregon Health Plan (OHP)**, **Address:** PO Box 14015, Salem, OR 97309, **Phone:** 1-800-273-0557, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oregon.gov/oha/hsd/ohp/Pages/index.aspx
Pennsylvania	**Community HealthChoices**, **Address:** Office of Medical Assistance Programs (OMAP) Health and Human Services Building Room 515, PO Box 2675 Harrisburg, PA 17105, **Phone:** 1-800-692-7462, 1-866-550-4355, **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 4:45 PM, **Website:** pa.gov/agencies/dhs/resources/medicaid/chc
Puerto Rico	**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
Rhode Island	**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 3:00 PM, **Website:** eohhs.ri.gov/consumer/health-care
South Carolina	**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/
South Dakota	**South Dakota Medicaid**, **Address:** Department of Social Services, 700 Governors Drive, Pierre, SD 57501, **Phone:** 1-800-597-1603, 605-773-3495, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** dss.sd.gov/medicaid/
Tennessee	**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
Texas	**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 6:00 PM, **Website:** hhs.texas.gov/services/health/medicaid-chip

	State Medicaid Office
U.S. Virgin Islands	**Virgin Islands Medicaid Program**, **Address:** Department of Human Services, 1303 Hospital Ground, Knud Hansen Complex/Building A, St. Thomas, VI 00802; 3012 Golden Rock, Christiansted, St. Croix, VI 00820, **Phone:** DHS Head Quarters in St. John, Cruz Bay, St. John: **340-715-6929** (Customer Support), **340-774-0930** (St. Thomas), **340-718-2980** (St. Croix), **340-776-6334** (St. John), **TTY:** **711**, **Hours:** Monday–Friday 7:00 AM to 7:00 PM, **Website:** **dhs.vi.gov/office-of-medicaid/**
Utah	**Utah Medicaid**, **Address:** Department of Health and Human Services, Cannon Health Building, PO Box 143106, Salt Lake City, UT 84114-3106, **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/**
Vermont	**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**
Virginia	**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/**
Washington	**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/**
West Virginia	**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**
Wisconsin	**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 **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**
Wyoming	**Wyoming Medicaid**, **Address:** Wyoming Department of Health P.O. Box 1248 Cheyenne, WY 82003-1248, **Phone:** **1-855-294-2127**, **TTY:** **1-855-329-5205** 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:** **wyomingmedicaid.com**

	State Health Insurance Assistance Program (SHIP)
Alabama	**Alabama State Health Insurance Assistance Program**, **Address:** RSA Tower, 201 Monroe Street, Suite 350, Montgomery, AL 36104, **Phone:** **1-800-243-5463**, **334-242-5743**, **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:** **alabamaageline.gov/ship/**

	State Health Insurance Assistance Program (SHIP)
Alaska	**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
Arizona	**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:** azship.org/
Arkansas	**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:** insurance.arkansas.gov/consumer-services/senior-health/
California	**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/
Colorado	**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
Connecticut	**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:** 1-860-247-0775 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
Delaware	**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 4:30 PM, **Website:** insurance.delaware.gov/divisions/dmab/
District of Columbia	**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
Florida	**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/

	State Health Insurance Assistance Program (SHIP)
Georgia	**Georgia SHIP**, **Address:** Department of Human Services, Division of Aging Services, 47 Trinity Ave. S.W., Atlanta, GA 30334, **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
Guam	**Guam State Health Insurance Assistance Program (SHIP)**, **Address:** 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
Hawaii	**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:** hawaiiship.org/
Idaho	**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/
Illinois	**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:** ilaging.illinois.gov/ship.html
Indiana	**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/
Iowa	**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 4:00 PM, **Website:** shiip.iowa.gov/
Kansas	**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/services-programs/aging/medicare-programs/senior-health-insurance-counseling-for-kansas-shick
Kentucky	**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
Louisiana	**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, 225-342-5301, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 4:30 PM, **Website:** ldi.la.gov/consumers/senior-health-shiip

	State Health Insurance Assistance Program (SHIP)
Maine	**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–Thursday 9:00 AM to 5:00 PM, Friday 9:00 AM to 4:00 PM, **Website:** maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
Maryland	**Maryland State Health Insurance Assistance Program**, **Address:** Maryland Department of Aging, 36 S Charles Street, 12th Floor Baltimore, Maryland 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
Massachusetts	**SHINE (Serving Health Insurance Needs of Everyone) (Massachusetts SHIP)**, **Address:** Executive Office of Aging & Independence, 1 Ashburton Place, 5th 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
Michigan	**Michigan Medicare Assistance Program (MMAP)**, **Address:** Department of Health & Human Services, 235 S. Grand Ave, PO Box 30195, Lansing, Michigan 48909, **Phone:** 1-800-803-7174 or 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:** michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program
Minnesota	**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/
Mississippi	**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/
Missouri	**Missouri SHIP**, **Address:** Department of Commerce & Insurance, 601 W. Nifong Blvd., Ste. A, Columbia, MO 65203-6804, **Phone:** 1-800-390-3330, **TTY:** 1-800-735-2966 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 4:00 PM, **Website:** missouriship.org
Montana	**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

	State Health Insurance Assistance Program (SHIP)
Nebraska	**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 4:30 PM, **Website:** doi.nebraska.gov/ship-smp
Nevada	**Nevada State Health Insurance Assistance Program (SHIP)**, **Address:** Aging and Disability Service Division Administrative Office, 1550 College Parkway 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_(MAP)/MAP_Prog/
New Hampshire	**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 8:30 AM to 4:30 PM, **Website:** servicelink.nh.gov
New Jersey	**New Jersey State Health Insurance Assistance Program (SHIP)**, **Address:** State Health Insurance Assistance Program, Division of Aging Services, 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
New Mexico	**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 5:00 PM, **Website:** aging.nm.gov
New York	**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
North Carolina	**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
North Dakota	**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, **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
Ohio	**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, **TTY:** 711, **Hours:** Monday–Friday 7:30 AM to 5:00 PM, **Website:** insurance.ohio.gov/about-us/divisions/oshiip

	State Health Insurance Assistance Program (SHIP)
Oklahoma	**Oklahoma State Health Insurance Counseling Program (SHIP)**, **Address:** Insurance Department, 400 NE 50th Street, Oklahoma City, OK 73105, **Phone:** 1-800-763-2828, 405-521-2828, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** oid.ok.gov/consumers/information-for-seniors/
Oregon	**Oregon Senior Health Insurance Benefits Assistance (SHIBA)**, **Address:** Department of Consumer and Business Services 350 Winter Street, NE, Room 330 Salem OR 97309-0405, **Phone:** 1-800-722-4134, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** shiba.oregon.gov/
Pennsylvania	**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:** pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling.html
Puerto Rico	**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 (San Juan), **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
Rhode Island	**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
South Carolina	**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
South Dakota	**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 - Hillsview Plaza, c/o 500 E. Capitol Avenue, Pierre, SD 57501, **Phone:** 1-800-536-8197 (Southeastern SD), 1-877-286-9072 (Western SD), 1-605-432-8801 (Northeastern SD), **TTY:** 711, **Hours:** Monday–Friday 9:00 AM to 4:30 PM, **Website:** dhs.sd.gov/en/ltss/shiine
Tennessee	**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/
Texas	**Texas Health Information, Counseling and Advocacy Program (HICAP)**, **Address:** Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin TX 78751, **Phone:** 1-800-252-9240, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** hhs.texas.gov/services/health/medicare

	State Health Insurance Assistance Program (SHIP)
U.S. Virgin Islands	**Virgin Islands State Health Insurance Assistance Program (VISHIP)**, **Address:** 1131 King Street, Ste. 101, Christiansted, St. Croix, VI 00820; 5049 Kongens Gode, St. Thomas, VI 00802, **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:** ltg.gov.vi/departments/vi-ship-medicare/
Utah	**Utah Senior Health Insurance Information Program (SHIP)**, **Address:** Department of Human Services 195 North 1950 West Salt Lake City UT 84116, **Phone:** 1-800-541-7735, **TTY:** 711, **Hours:** Monday–Friday 8:00 AM to 5:00 PM, **Website:** daas.utah.gov/seniors/
Vermont	**Vermont State Health Insurance Assistance Program (SHIP)**, **Address:** Vermont Association of Area Agencies on Aging 476 Main Street, Suite #3 Winooski VT 05404, **Phone:** 1-800-642-5119, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 4:30 PM, **Website:** asd.vermont.gov/services/ship
Virginia	**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, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** www.vda.virginia.gov/vicap.htm
Washington	**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 8:30 AM to 4:30 PM, **Website:** insurance.wa.gov/insurance-resources/medicare
West Virginia	**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:** 304-558-3317, 877-987-4463, **TTY:** 711, **Hours:** Monday–Friday 8:30 AM to 5:00 PM, **Website:** wvship.org/
Wisconsin	**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 262-347-3045 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
Wyoming	**Wyoming State Health Insurance Information Program (WSHIIP)**, **Address:** Wyoming Dept. of Insurance, 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/

APPENDIX B:

*Aetna Medicare Plan (HMO) Service Areas**

Appendix B. Aetna Medicare Plan (HMO) 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 (HMO) 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 HMO

Alabama
Jefferson • Limestone • Madison • Mobile • Shelby
Arizona
Graham • Maricopa • Mohave • Pima • Pinal • Santa Cruz • Yavapai
California
Alameda • Fresno • Kern • Los Angeles • Marin • Orange • Riverside • San Bernardino • San Diego • San Francisco • Santa Clara • 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 • Duval • Escambia • Hernando • Highlands • Hillsborough • Lake • Lee • Manatee • Marion • Martin • Miami-Dade • Nassau • Orange • Osceola • Palm Beach • Pasco • Pinellas • Polk • Santa Rosa • Sarasota • Seminole • St. Johns • St. Lucie • Sumter • Volusia
Georgia
Baldwin • Barrow • Bartow • Bibb • Bryan • Butts • Camden • Chatham • Chattahoochee • Cherokee • Clarke • Clayton • Cobb • Columbia • Coweta • Crawford • Dawson • DeKalb • Douglas • Effingham • Fayette • Forsyth • Fulton • Glynn • Greene • Gwinnett • Hall • Haralson • Harris • Heard • Henry • Houston • Jackson • Jasper • Madison • McDuffie • McIntosh • Monroe • Morgan • Muscogee • Newton • Oconee • Paulding • Pickens • Pike • Polk • Putnam • Richmond • Rockdale • Spalding • Taliaferro
Idaho
Ada • Canyon
Illinois
Cook • DuPage • Kane • Kankakee • Madison • McHenry • Monroe • Peoria • St. Clair • Tazewell • Will
Indiana
Allen • Boone • Hamilton • Hancock • Hendricks • Johnson • Lake • Madison • Marion • Monroe • Morgan • Porter • Tippecanoe

Iowa
Black Hawk • Dallas • Johnson • Linn • Polk • Scott • Story • Woodbury
Kansas
Douglas • Johnson • Leavenworth • Sedgwick • Shawnee • Wyandotte
Kentucky
Boone • Bullitt • Campbell • Fayette • Franklin • Hardin • Jefferson • Jessamine • Kenton • Madison • McCracken • Oldham • Scott • Warren
Louisiana
Ascension • Bossier • Caddo • East Baton Rouge • Jefferson • Orleans • St. Tammany
Maine
Androscoggin • Cumberland • Franklin • Kennebec • Lincoln • Oxford • Penobscot • Piscataquis • Sagadahoc • Somerset • Waldo • York
Maryland
Anne Arundel • Baltimore • Baltimore City • Calvert • Carroll • Cecil • Charles • Frederick • Harford • Howard • Kent • Montgomery • Prince George's • Queen Anne's • St. Mary's • Talbot • Washington • Wicomico
Massachusetts
Bristol • Essex • Hampden • Middlesex • Norfolk • Plymouth • Suffolk • Worcester
Michigan
Bay • Genesee • Jackson • Lapeer • Livingston • Macomb • Monroe • Oakland • Saginaw • Shiawassee • St. Clair • Washtenaw • Wayne
Missouri
Boone • Buchanan • Cass • Christian • Clay • Cole • Franklin • Greene • Jackson • Jasper • Jefferson • Platte • Saint Charles • Saint Francois • Saint Louis • Saint Louis City
Nebraska
Douglas • Lancaster • Sarpy
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 York
Albany • Bronx • Broome • Cayuga • Chautauqua • Chemung • Columbia • Dutchess • Erie • Genesee • Greene • Kings • Madison • Nassau • New York • Niagara • Oneida • Onondaga • Orange • Oswego • Putnam • Queens • Rensselaer • Richmond • Rockland • Saratoga • Schenectady • Suffolk • Sullivan • Tioga • Tompkins • Ulster • Westchester

North Carolina
Alamance • Alexander • Buncombe • Burke • Cabarrus • Caldwell • Catawba • Chatham • Cleveland • Davidson • Davie • Durham • Edgecombe • Forsyth • Franklin • Gaston • Granville • Guilford • Haywood • Henderson • Iredell • Johnston • Lincoln • Mecklenburg • Nash • Orange • Person • Pitt • Randolph • Rockingham • Rowan • Rutherford • Stanly • Stokes • Surry • Union • Wake • Wilkes • Wilson • Yadkin
Ohio
Adams • Allen • Ashland • Ashtabula • Auglaize • Belmont • Brown • Butler • Carroll • Champaign • Clark • Clermont • Clinton • Columbiana • Coshocton • Crawford • Cuyahoga • Delaware • Erie • Fairfield • Fayette • Franklin • Fulton • Geauga • Greene • Guernsey • Hamilton • Hancock • Hardin • Henry • Highland • Hocking • Holmes • Huron • Jefferson • Knox • Lake • Licking • Logan • Lorain • Lucas • Madison • Mahoning • Marion • Medina • Miami • Montgomery • Morgan • Morrow • Muskingum • Noble • Ottawa • Perry • Pickaway • Pike • Portage • Preble • Putnam • Richland • Ross • Sandusky • Scioto • Seneca • Shelby • Stark • Summit • Trumbull • Tuscarawas • Union • Warren • Wayne • Wood
Oklahoma
Canadian • Cleveland • Lincoln • Oklahoma • Tulsa
Oregon
Clackamas • Jackson • Marion • Multnomah • Polk • Washington • Yamhill
Pennsylvania
Adams • Allegheny • Armstrong • Beaver • Bedford • Berks • Blair • Bradford • Bucks • Butler • Cambria • Carbon • Centre • Chester • Clarion • Clearfield • Clinton • Columbia • Crawford • Cumberland • Dauphin • Delaware • Erie • Fayette • Franklin • Fulton • Greene • Huntingdon • Indiana • Jefferson • Juniata • Lackawanna • Lancaster • Lawrence • Lebanon • Lehigh • Luzerne • Lycoming • Mercer • Monroe • Montgomery • Northampton • Northumberland • Perry • Philadelphia • Pike • Schuylkill • Snyder • Somerset • Sullivan • Susquehanna • Venango • Washington • Wayne • Westmoreland • Wyoming • York
Rhode Island
Bristol • Kent • Newport • Providence • Washington
South Carolina
Anderson • Cherokee • Greenville • Greenwood • Oconee • Pickens • Spartanburg • Sumter • York
Tennessee
Cheatham • Davidson • Dickson • Maury • Putnam • Robertson • Rutherford • Shelby • Sumner • Trousdale • Williamson • Wilson
Texas
Atascosa • Austin • Bandera • Bastrop • Bee • Bexar • Brazoria • Caldwell • Cameron • Chambers • Collin • Comal • Cooke • Dallas • Delta • Duval • Ector • El Paso • Ellis • Fannin • Fort Bend • Galveston • Gregg • Grimes • Guadalupe • Hardin • Harris • Hays • Henderson • Hidalgo • Hill • Hood • Hopkins • Jefferson • Johnson • Kendall • Liberty • Lubbock • Matagorda • Medina • Midland • Montague • Montgomery • Navarro • Nueces • Orange • Palo Pinto • Parker • Potter • Rains • Randall • Rockwall • San Jacinto • Smith • Somervell • Tarrant • Travis • Van Zandt • Walker • Waller • Webb • Wharton • Williamson • Wilson
Utah
Cache • Davis • Salt Lake • Utah • Weber

Virginia
Albemarle • Alexandria City • Amelia • Arlington • Botetourt • Charlottesville City • Chesapeake City • Chesterfield • Colonial Heights City • Craig • Danville City • Essex • Fairfax • Fairfax City • Falls Church City • Fauquier • Franklin • Franklin City • Fredericksburg City • Gloucester • Goochland • Hampton City • Hanover • Henrico • Henry • Hopewell City • James City • King and Queen • King William • Loudoun • Manassas City • Manassas Park City • Martinsville City • Mathews • Middlesex • Montgomery • New Kent • Newport News City • Norfolk City • Petersburg City • Pittsylvania • Poquoson City • Portsmouth City • Powhatan • Prince William • Radford City • Richmond City • Roanoke • Roanoke City • Salem City • Spotsylvania • Stafford • Staunton City • Suffolk City • Sussex • Virginia Beach City • Waynesboro City • Williamsburg City • York
Washington
Clark • King • Kitsap • Pierce • Snohomish • Spokane • Thurston
West Virginia
Berkeley • Cabell • Harrison • Jefferson • Kanawha • Marion • Marshall • Mason • Mercer • Monongalia • Ohio • Putnam • Raleigh • Wood

Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on your ID card. (English)

እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ በመታወቂያ ካርድዎ (ID) ላይ ወዳለው ቁጥር ይደውሉ። (Amharic)

صول على خدمات اللغة مجانًا، اتصل بالرقم الموجود على بطاقة العضوية الخاصة بك. (Arabic)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa Waraqaa Eenyummeessaa (ID) keessan irra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro figurant sur votre carte d'identité. (French)

Pou w jwenn aksè ak sèvis lang gratis pou ou, rele nimewo ki sou kat idantite w la. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer auf Ihrem Ausweis an. (German)

Inā ake ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe i ka helu ma kou kāleka ID. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj nyob ntawm koj daim npav ID. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato sul tuo tesserino identificativo. (Italian)

無料の言語サービスをご利用いただくには、ご自身のIDカードに記載されている番号 にお電話ください。 (Japanese)

လာကမၤန့ၣ် ကျဲဘၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၣ်ဘူးၣ်လၣ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနိၣ်ဂံၢ် လၢအအိၣ် ဖဲန ID အဖိခိၣ်နၣ် ၌ တကွၢ်. (Karen)

무료로 언어 서비스를 이용하려면 ID 카드에 적힌 전화번호로 전화하세요. (Korean)

ເພ່ ອ ້ ຂ ້ າ ເ ຖ ິ ງ ການ ບ ໍ ລ ິ ການ ພ າ ສ າ ໂ ດ ຍ ບ ເ ສ ຍ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ ໃ ດ ໆ ແ ກ ່ ທ ່ ານ, ໃ ຫ ້ ໂ ທ ຫ າ ເ ບ ີ ໍ ່ ຍ ໃ ນ ບ ັ ດ ປ ະ ຈ ໍ າ ຕ ົ ວ ຂ ອ ງ ທ. (Laotian)

ដើម ី ទ ទ ួ ល ន េ ស ផ ែ ក ន េ យ ម ិ ន គ ិ ត ថ ៃ ព ី អ ក ស ូ ម ទ ូ រ ស ព ទ ៃ ល េ ខ ដ ល ន េ ល ើ ត ស ល ់ ខ ន រ ប ស ់ អ ក ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany na karcie ID. (Polish)

Ligue para o número que está no seu cartão de identificação para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному на вашей идентификационной карте. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que figura en su tarjeta de identificación. (Spanish)

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa iyong ID card. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại trên thẻ ID của quý vị. (Vietnamese)

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Aetna Medicare Plan (HMO) Member Services

Member Services – Contact Information	
Call	Please call the telephone number on your member ID card or **1-888-267-2637** 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 14089 Lexington, KY 40512
Website	**AetnaRetireePlans.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, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*