Evidence of Coverage

Aetna Assure Premier Plus (HMO D-SNP)

January 1, 2025 – December 31, 2025

Your Health and Drug Coverage under Aetna Assure Premier Plus (HMO D-SNP)

Evidence of Coverage Introduction

This *Evidence of Coverage*, otherwise known as the *Member Handbook*, tells you about your coverage under our plan through December 31, 2025. It explains health care services, including behavioral health (mental health and substance use disorder treatment) services, prescription drug coverage, and Managed Long-Term Services and Supports (MLTSS). Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Evidence of Coverage*.

This is an important legal document. Keep it in a safe place.

When this *Evidence of Coverage* says "we," "us," "our," or "our plan," it means Aetna Assure Premier Plus (HMO D-SNP).

This document is available for free in Spanish. Este documento está disponible sin cargo en español.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

- Aetna Assure Premier Plus (HMO D-SNP) wants to make sure you understand your health plan information. If a different language or format works better for you, call Member Services at the number listed at the bottom of this page to request a change. (This is called a "standing request.")
- We will continue sending you mailings and other communications in your requested format.
- If you want to change your standing request for a preferred language or format, call Member Services.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-844-362-0934 (TTY: 711). Someone that speaks Spanish can help you. This is a free service.

If you have questions, please call Aetna Assure Premier Plus (HMO D-SNP) at 1-844-362-0934 (TTY: 711), 8 AM to 8 PM, 7 days a week. The call is free.
For more information, visit AetnaMedicare.com/NJDSNP.

Form Approved
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Multi-Language Insert
Multi-language Interpreter Services

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-362-0934. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-362-0934。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-362-0934。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-362-0934. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-362-0934. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-362-0934. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-362-0934. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-362-0934. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-362-0934. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-844-362-0934 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-362-0934. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-362-0934. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-362-0934. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-362-0934. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-362-0934. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-362-0934. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-844-362-0934. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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

2025 EVIDENCE OF COVERAGE

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Disclaimers

- Aetna Assure Premier Plus (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the New Jersey Medicaid Program. Enrollment in Aetna Assure Premier Plus (HMO D-SNP) depends on contract renewal.
- When joining this plan:
    1. You must use in-network providers, DME (Durable Medical Equipment) suppliers, and pharmacies.
    2. You will be enrolled automatically into Medicaid (NJ FamilyCare) coverage under our plan, and disenrolled from any Medicaid (NJ FamilyCare) plan you are currently enrolled in. All of your Medicaid-covered services, items, and medications will then be covered under our plan, and you must get them from in-network providers.
    3. You will be enrolled automatically into Part D coverage under our plan, and you will be automatically disenrolled from any other Medicare Part D or creditable coverage plan in which you are currently enrolled.
    4. You must understand and follow our plan's rules on referrals.
- Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
- The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.
- Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies.
- Other pharmacies and providers are available in our network.
- SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.
- Coverage under Aetna Assure Premier Plus (HMO D-SNP) is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Aetna Assure Premier Plus (HMO D-SNP), a health plan that covers all of your Medicare and NJ FamilyCare (Medicaid) services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 1 Getting started as a member

A. Welcome to our plan

Our plan provides Medicare and NJ FamilyCare (Medicaid) services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have Care Managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

B. Information about Medicare and NJ FamilyCare (Medicaid)

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. NJ FamilyCare

NJ FamilyCare is the name of the New Jersey Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. NJ FamilyCare helps people with limited incomes and resources pay for MLTSS and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of New Jersey approved our plan. You can get Medicare and NJ FamilyCare services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of New Jersey allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and NJ FamilyCare services is not affected.

C. Advantages of our plan

You will now get all your covered Medicare and NJ FamilyCare services from our plan, including prescription drugs. **You do not pay anything to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a Care Manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and Care Manager.
- Your care team and Care Manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in **New Jersey**: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren.

Only people who live in our service area can join our plan.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Evidence of Coverage* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for full NJ FamilyCare benefits.

If you lose eligibility but can be expected to regain it within three months, then you are still eligible for our plan.

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs, including but not limited to; walking, bathing, eating, toileting, and dressing.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a Care Manager, or other health person that you choose.

A Care Manager is a person trained to help you manage the care you need. You get a Care Manager when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your Care Manager and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and MLTSS or other services.

Your care plan includes:

- your HRA findings,
- gaps in your care,
- your preferences to ensure you receive care based on your needs,
- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Your monthly costs for Aetna Assure Premier Plus (HMO D-SNP)

Our plan has no premium.

H1. Monthly Medicare Part B premium

Medicaid pays your Medicare Part B premium for you when you are enrolled in this plan.

I. Your *Evidence of Coverage*

Your *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Evidence of Coverage* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an *Evidence of Coverage* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website at the web address at the bottom of the page.

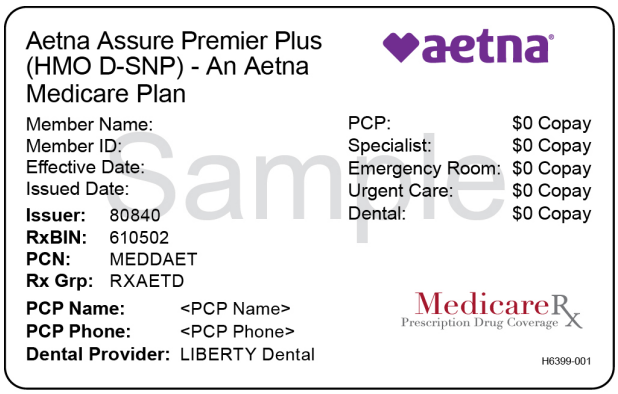
The contract is in effect for the months you are enrolled in our plan between January 1, 2025 and December 31, 2025.

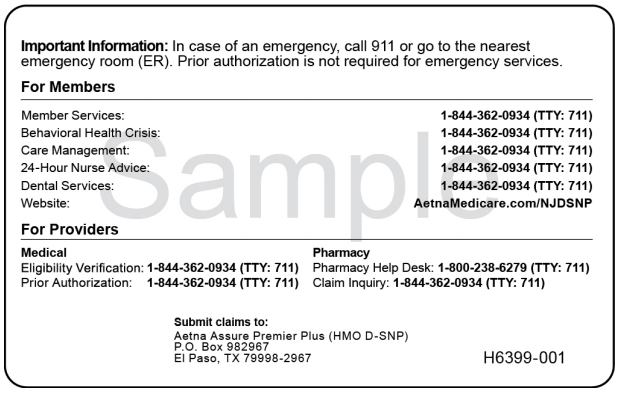
J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory,* and information about how to access a *List of Covered Drugs,* also known as a *Formulary.*

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and NJ FamilyCare services, including MLTSS, behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:





If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your NJ FamilyCare card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member

Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

The *Provider and Pharmacy Directory* lists our network providers, durable medical equipment suppliers, and network pharmacies.

Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - MLTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "*Formulary*" for short. It tells you which prescription drugs our plan covers.

The *Formulary* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

Each year, we send you information about how to access the *Formulary*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs

during the month. This EOB is not a bill. The EOB has more information about the drugs you take. **Chapter 6** of your *Evidence of Coverage* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the number at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get.**

Tell us right away about the following:

- changes to your name, your address, or your phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Evidence of Coverage.*

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your Care Manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 2 Important phone numbers and resources

A. Member Services

CALL	1-844-362-0934 (TTY: **711**). This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week.
WRITE	Aetna Assure Premier Plus (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	AetnaMedicare.com/NJDSNP

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Evidence of Coverage*.
- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Evidence of Coverage* or contact Member Services.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
  - You can call us and explain your complaint at 1-844-362-0934 (TTY: **711**).
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can contact the state's Medicaid program with a complaint by calling the NJ Department of Human Services, Division of Medical Assistance & Health Services at **1-800-701-0710** (TTY: **711**).
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Evidence of Coverage.*

- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs.
    - This applies to your Medicare Part D drugs and NJ FamilyCare covered drugs and over-the-counter drugs.
    - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage.*
- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage.*
- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Evidence of Coverage.*
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Evidence of Coverage.*

B. Your Care Manager

Care Managers can help with your special health care needs. They are nurses, social workers and licensed counselors, and they understand your health conditions. They work with your doctors to help get you the care that you need. After you are enrolled, a Care Manager will be assigned to you.

If you would like to get connected to your Care Manager, call Member Services at 1-844-362-0934 (TTY:**711**). They are here for you 8 AM to 8 PM, 7 days a week.

If you would like to request a new Care Manager, just call Member Services at 1-844-362-0934 (TTY:**711**). We're here for you 8 AM to 8 PM, 7 days a week.

CALL	1-844-362-0934 (TTY: **711**). This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. Hours of operation are 8 AM to 8 PM, 7 days a week.

WRITE	Aetna Assure Premier Plus (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998

Contact your Care Manager to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder treatment) services
- questions about transportation
- questions about Managed Long Term Services and Supports (MLTSS)

C. New Jersey State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In New Jersey, the SHIP is called New Jersey State Health Insurance Assistance Program (SHIP).

The SHIP is not connected with any insurance company or health plan.

CALL	**1-800-792-8820** Monday–Friday 8:30 AM to 4:30 PM
TTY	**711**
WRITE	NJ State Health Insurance Assistance Program, Division of Aging Services, PO Box 807, Trenton, NJ 08625
WEBSITE	nj.gov/humanservices/doas/services/q-z/ship/index.shtml

Contact SHIP for help with:

- questions about Medicare
- SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our plan.

CALL	**1-866-815-5440**
TTY	**711**
WRITE	BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23450
WEBSITE	http://www.livantaqio.com/en/states/new_jersey

Contact Livanta for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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, or CMS.

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 call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.

WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

F. NJ FamilyCare (Medicaid)

NJ FamilyCare helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the NJ Department of Human Services, Division of Medical Assistance & Health Services.

Because you are eligible for and enrolled in both Medicare and Medicaid, your coverage through our plan includes coverage for all of the benefits you are entitled to under Medicaid managed care (NJ FamilyCare). As a result, Aetna Assure Premier Plus (HMO D-SNP) covers all of your Medicaid benefits such as hearing aids, routine vision exams, and comprehensive dental services. Additionally, Medicaid pays your Part B premium for you.

CALL	NJ Department of Human Services, Division of Medical Assistance & Health Services **1-800-701-0710** Monday and Thursday 8:00 AM to 8:00 PM, Tuesday, Wednesday, Friday 8:00 AM to 5:00 PM
TTY	**711**
WRITE	NJ Department of Human Services, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712
WEBSITE	state.nj.us/humanservices/dmahs/

G. Office of the Insurance Ombudsman

The Office of the Insurance Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Insurance Ombudsman also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	**1-800-446-7467** Monday–Friday 9:00 AM to 5:00 PM
TTY	**711**
WRITE	The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, PO Box 472, Trenton, NJ 08625-0472
WEBSITE	state.nj.us/dobi/ombuds.htm

H. New Jersey Office of the State Long-Term Care Ombudsman

The New Jersey Office of the State Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The New Jersey Office of the State Long-Term Care Ombudsman is not connected with our plan or any insurance company or health plan.

CALL	**1-877-582-6995** Monday–Friday 8:30 AM to 4:30 PM
TTY	**711**
WRITE	NJ Long-Term Care Ombudsman, PO Box 852, Trenton, NJ 08625-0852
WEBSITE	nj.gov/ooie/

I. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website (www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this "Extra Help."

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 call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

J. Social Security

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

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

CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

K. Railroad Retirement Board (RRB)

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

CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are *not* free.
WEBSITE	www.rrb.gov

L. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: **1-877-486-2048**) with questions related to your Medicare coverage under this plan.

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

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your Care Management, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 3 Using our plan's coverage for your health care and other covered services

A. Information about services and providers

Services are health care, Managed Long-Term Services and Supports (MLTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and MLTSS are in **Chapter 4** of your *Evidence of Coverage*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Evidence of Coverage*.

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain MLTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and NJ FamilyCare. This includes behavioral health and Managed Long-Term Services and Supports (MLTSS).

Our plan will generally pay for health care services, behavioral health services, and MLTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- The care must be **medically necessary.** By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
    - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to **Section D1** in this chapter).
- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
    - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to **Section I** in this chapter).
    - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Prior authorization should be obtained from the plan prior to seeking care. In this situation, we cover the care at no cost to you.
    - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.

C. Your Care Manager

C1. What a Care Manager is

A Care Manager is a trained person who works for our plan to make sure you get the health care you need. A Care Manager, along with others on the care team, will work with you to complete health risk assessments in order to create your personal care plan. Your Care Manager will also help you obtain benefits, coordinate appointment scheduling, and assist with accessing community resources and support.

C2. How you can contact your Care Manager

A Care Manager will be assigned to you when you become a member. You Care Manager will contact you when you enroll in the plan. You can also call Member Services if you need help getting in contact with your Care Manager.

C3. How you can change your Care Manager

If you would like to change your Care Manager, please contact our Member Services department at the number below.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does 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.

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

- General Practitioner
- Internist
- Family Practitioner
- Geriatrician
- Physician Assistants
- Nurse Practitioners

Please refer to your *Provider and Pharmacy Directory* or go to our website at AetnaMedicare.com/NJDSNP-find-provider 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 with other providers. Your PCP will help you find a specialist and will arrange for covered services you get as a member of our plan. Some of the services that the PCP will coordinate include:

- x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions

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

What is the role of the PCP in making decisions about or obtaining prior authorization?
In some cases, your PCP (or other provider), or you as the plan member, may need to request advance approval from our Medical Management Department for certain types of services or tests. This is called getting **prior authorization**. **Chapter 4** lists the services and items that require **prior authorization**.

Your choice of PCP
You can select your PCP by using the *Provider and Pharmacy Directory,* by accessing our website at AetnaMedicare.com/NJDSNP-find-provider, or getting help from Member Services.

If you have not selected a PCP, a PCP will be selected for you. You can change your PCP (as explained later in this section) for any reason, and at any time, by contacting Member Services.

Option to change your PCP
You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

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.

Under certain circumstances, you may continue receiving covered services from a participating physician or other health care professional who has left the network for up to four months beyond the effective date of termination (the end of the notice period).

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- Pregnancy – up to the postpartum evaluation (up to six weeks after delivery)
- Post-operative follow-up care (up to six months)
- Oncological treatment (up to one year)

- Psychiatric treatment (up to one year)

D2. Care from specialists and other network providers

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

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

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.

- Your PCP may refer you to a specialist, but you can go to any specialist in our network without a referral. Please refer to the *Provider and Pharmacy Directory* or access our website at AetnaMedicare.com/NJDSNP-find-provider for a complete listing of PCPs and other participating providers in your area.

What is the role of the PCP in making decisions about or obtaining prior authorization?
In some cases, your PCP (or other provider), or you as the plan member, may need to request advance approval from our Medical Management Department for certain types of services or tests. This is called getting **prior authorization**. **Chapter 4** lists the services and items that require **prior authorization**.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers changes during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- Under certain circumstances, you may continue receiving covered services from a provider who has left our network for up to four months beyond the effective date of termination (the end of the notice period).
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues. If you are undergoing certain courses of treatment, you may be able to receive longer periods of care as indicated below:
  - Pregnancy (up to the postpartum evaluation): up to six weeks after delivery

  - Post-operative follow-up care (care given after surgery): up to six months
  - Oncological treatment (treatment for cancer): up to one year
  - Psychiatric treatment (mental health treatment with a psychiatrist): up to one year
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization should be obtained from the plan prior to seeking care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

Under certain circumstances, for up to four months beyond the effective date of termination (the end of the notice period), you may continue receiving covered services from a provider who has left our network.

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- pregnancy – up to the postpartum evaluation (up to six weeks after delivery)
- post-operative follow-up care (up to six months)
- oncological treatment (up to one year)
- psychiatric treatment (up to one year)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. You may contact Member Services at the number below for assistance. You may also look up participating providers using the *Provider and Pharmacy Directory* AetnaMedicare.com/NJDSNP-find-provider.

D4. 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 four exceptions*:

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider.
- If you need medical care that Medicare or NJ FamilyCare 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. Prior authorization should be obtained 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 may receive Family Planning services through out-of-network providers. In these cases, the services will be covered directly through Medicaid fee-for-service.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or NJ

FamilyCare.

- We cannot pay a provider who is not eligible to participate in Medicare and/or NJ FamilyCare.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. Managed Long-term services and supports (MLTSS)

The MLTSS program provides home- and community-based services for members that require the level of care typically provided in a nursing facility and allows them to receive necessary care in a residential or community setting.

MLTSS services include (but are not limited to): assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and non-medical transportation. MLTSS is available to members who meet certain clinical and financial requirements. If you would like more information, or to ask for an assessment to determine your eligibility for MLTSS, call your Care Manager at 1-844-362-0934 (TTY: **711**), 8 AM to 8 PM, 7 days a week.

F. Behavioral health (mental health and substance use disorder treatment) services

Your plan covers a number of behavioral health benefits for you. Behavioral health includes both mental health services and substance use disorder treatment services. You will find details in the Benefits Chart in **Chapter 4**.

When requesting prior authorization or making arrangements to receive behavioral health services members and providers should call Member Services at 1-844-362-0934 (TTY: **711**).

G. How to get self-directed care through the Personal Preference Program (PPP)

G1. What self-directed care is

The New Jersey Personal Preference Program (PPP) offers a way for NJ FamilyCare members who qualify for Personal Care Assistant (PCA) services to direct and manage the PCA services.

G2. Who can get self-directed care

PCA services are non-emergency, health related tasks through NJ FamilyCare. Tasks include help with activities of daily living (ADLs) and with household duties essential to the patient's health and comfort, such as bathing, dressing, meal preparation, and light housekeeping.

G3. How to get help in employing personal care providers

You get to choose who you hire to provide PCA services. You can hire a relative, friend or neighbor. Ask your Care Manager for help with this process. If you need help choosing services, or your PCA, you can choose someone you trust to decide for you.

You also will work with a financial counselor to make a plan to manage payment to your PCA.

To take part in PPP, you need to be:

1. Approved for Personal Care Assistant Services (PCA), and need PCA services for at least six months.
2. Able to direct and manage your services or choose someone to decide for you

If you would like to request a PCA assessment for enrollment into PPP, please contact your Care Manager at 1-844-362-0934 (TTY: **711**)8 AM to 8 PM, 7 days a week.

H. Transportation services

- Non-emergency transportation, including mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and delivery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). These services are paid for directly by Medicaid (also known as Medicaid Fee-for-Service).

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
  - There is not enough time to safely transfer you to another hospital before delivery
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible**. Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do **not** need to

use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services at 1-844-362-0934 (TTY: **711**). Hours of operation are 8 AM to 8 PM, 7 days a week.

Covered services in a medical emergency
Our plan covers worldwide services outside 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 Benefits Chart in **Chapter 4** 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.

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage.*

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Post-stabilization care means the covered services related to an emergency medical condition that are provided after your emergency medical condition has been stabilized.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency
Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For

example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area
In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

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

Urgently needed care outside our plan's service area
When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

Our plan covers worldwide services outside 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 Benefits Chart in **Chapter 4** 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.

I3. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: AetnaMedicare.com/NJDSNP.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

J. What to do if you are billed directly for services our plan covers

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill.

You should not pay the bill yourself. If you do, we may not be able to pay you back.

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do.

J1. What to do if our plan does not cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Evidence of Coverage*), **and**
- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 of your *Evidence of Coverage* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get

approval from us or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) and may be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.
If you plan to be in a clinical research study covered for enrollees by Original Medicare, we encourage you or your Care Manager to contact Member Services to let us know you will take part in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that is part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare or our plan has **not** approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

L. How your health care services are covered in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. 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 are against getting medical treatment that is "non-excepted."

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

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

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

Please see the Benefits Chart in **Chapter 4** for more information about inpatient hospital coverage and limitations.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you usually will not own DME, no matter how long you rent it.

In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and MA Plans in **Chapter 12**. You can also find more information about them in the *Medicare & You 2025* handbook. If you don't have a copy of this booklet,

you can get it at the Medicare website (www.medicare.gov/medicare-and-you) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, those **Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage.*

Table of Contents

Chapter 4 Benefits Chart

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Evidence of Coverage*. This chapter also explains limits on some services.

Because you get assistance from NJ FamilyCare, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Evidence of Coverage* for details about the plan's rules.

If you need help understanding what services are covered, call your Care Manager and/or Member Services at 1-844-362-0934 (TTY: **711**).

B. Rules against providers charging you for services

We don't allow our providers to bill you for in-network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your *Evidence of Coverage* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and NJ FamilyCare covered services according to the rules set by Medicare and NJ FamilyCare.
- The services (including medical care, behavioral health and substance use disorder treatment services, Managed Long Term Services and Supports (MLTSS), supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, the plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Evidence of Coverage* has more information about using network and

out-of-network providers.

- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- If you are within our plan's three-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, Medicaid-only benefits may not be covered by our plan. To find out if a benefit is Medicaid-only, and/or to find out if it will be covered, you can call Member Services at 1-844-362-0934 (TTY: **711**). All of your Medicare services, including Medicare Part D prescription drugs, will continue to be covered at $0 cost sharing (no copayments, coinsurance, or deductibles) during the period of deemed continued eligibility.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with bold type.
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.

- All preventive services are free. You will find this apple next to preventive services in the Benefits Chart.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:
  - Autoimmune disorders limited to:
    - Polyarteritis nodosa
    - Polymyalgia rheumatica
    - Polymyositis
    - Psoriasis
    - Rheumatoid arthritis
    - Systemic lupus erythematosus
  - Cancer
  - Cardiovascular disorders limited to:
    - Cardiac arrhythmias
    - Cardiac valve disease
    - Coronary artery disease
    - Peripheral vascular disease
    - Chronic venous thromboembolic disorder
  - Chronic alcohol and other drug dependence
  - Chronic and disabling mental health conditions limited to:
    - Anxiety
    - Bipolar disorders
    - Major depressive disorders
    - Paranoid disorder

    - Schizophrenia
    - Schizoaffective disorder
- Chronic heart failure
- Chronic lung disorders limited to:
    - Asthma
    - Chronic bronchitis
    - Chronic obstructive pulmonary disease (COPD)
    - Emphysema
    - Pulmonary fibrosis
    - Pulmonary hypertension
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD) requiring dialysis
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Neurologic disorders limited to:
    - Amyotrophic lateral sclerosis (ALS)
    - Epilepsy
    - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
    - Huntington's disease
    - Multiple sclerosis (MS)
    - Parkinson's disease
    - Peripheral neuropathy
    - Polyneuropathy
    - Spinal stenosis
    - Stroke-related neurologic deficit
- Severe hematologic disorders limited to:
    - Aplastic anemia
    - Chronic anemia
    - Hemophilia
    - Immune thrombocytopenic purpura
    - Myelodysplastic syndrome
    - Sickle-cell disease (excluding sickle-cell trait)
    - Chronic venous thromboembolic disorder
- Stroke
- Conditions that may cause cognitive impairment limited to:
    - Alzheimer's disease
    - Intellectual and developmental disabilities
    - Traumatic brain injuries

- Disabling mental illness associated with cognitive impairment, and
- Mild cognitive impairment

◦ Chronic pain
◦ Overweight, Obesity, and Metabolic Syndrome
◦ Osteoarthritis

- Refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information.
- Please contact us for additional information.

D. Our plan's Benefits Chart

You will find this apple next to the preventive services in the Benefits chart.

Services that our plan pays for		What you must pay and any additional requirements
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Acupuncture We pay for acupuncture visits if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. Acupuncture treatments must be stopped if you don't get better or if you get worse.	$0
	Aetna Medicare Extra Benefits Card You get an Aetna Medicare Extra Benefits Card to help pay for certain everyday expenses. On this card you get:	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Aetna Medicare Extra Benefits Card *(continued)*	
	An Over-the-Counter (OTC) Wallet with a monthly benefit amount (allowance). See the Over-the-Counter (OTC) Wallet section in Chapter 4 for more details. Members with one or more qualifying chronic conditions may be eligible to use their monthly benefit amount on/for other spending categories to help manage their overall health and wellness. See the **Help with Certain Chronic Conditions** row in this chart for more details. **Important:** • The Aetna Medicare Extra Benefits Card does not replace your member ID card. • You will receive a new card in the mail. It will include instructions on how to activate and use the card. • It is your responsibility to ensure that Aetna has the most up-to-date mailing address on file. Aetna is not responsible for misdirected, lost, or undelivered mail. • Aetna is not responsible for lost or stolen cards and any use associated with the card thereafter. If you need a replacement card, please call **1-844-428-8147** (TTY: **711**) to request a new card. In the meantime, you can access certain benefits by visiting CVS.com/Aetna. • Aetna is not responsible for lost funds due to personal circumstances in which you cannot use your benefit amount (e.g., hospital stay, travel, etc.). • The card can only be used at in-network retailers that accept Visa®. • The card cannot be used to pay for prescription drugs or products such as alcohol, tobacco, cannabis, firearms, and gift cards. For more information you can call **1-844-428-8147** (TTY: **711**) 7 days a week, 8 AM - 8 PM local time excluding federal holidays or visit CVS.com/Aetna.	
	**Alcohol misuse screening and counseling** We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0

Services that our plan pays for		What you must pay and any additional requirements
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. **Prior authorization is required for non-emergency transportation by fixed-wing aircraft.**	$0
	Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to Medicare preventive visit. You may schedule your annual routine physical once each calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. (See **Outpatient diagnostic tests and therapeutic services and supplies** for more information.)	$0
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0

Services that our plan pays for		What you must pay and any additional requirements
	Autism Spectrum Disorder services For all members with an Autism Spectrum Disorder (ASD) diagnosis, we pay for: • Applied Behavioral Analysis (ABA) • augmentative and alternative communication services and devices • Sensory Integration (SI) services • allied health services (physical therapy, occupational therapy, and speech therapy) • Developmental, Individual-differences, and Relationship-based (DIR) services, including but not limited to DIR Floortime and the Greenspan approach therapy **Prior authorization may be required and is the responsibility of your provider.**	$0
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and over • clinical breast exams once every 12 months	$0
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0

Services that our plan pays for		What you must pay and any additional requirements
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you are eating well.	$0
	Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease annually for all members 20 years of age or older, and more frequently if medically necessary. These blood tests also check for defects due to high risk of heart disease.	$0
	Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 12 months	$0
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment • clinical laboratory services • certain medical supplies • durable medical equipment • prefabricated orthoses • physical therapy services • diagnostic radiological services when they are prescribed by a chiropractor within their scope of practice	$0
	Colorectal cancer screening We pay for the following services:	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Colorectal cancer screening *(continued)*	
	• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Twice per calendar year. • Screening Guaiac-based fecal occult blood test for patients 45 years and older. Twice per calendar year. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
	Dental services This benefit includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. We pay for dental examinations, cleanings, fluoride treatment and any necessary x-rays. We pay for this service twice per rolling year. Examples of covered services include (but are not	$0
	This benefit is continued on the next page.	

	Services that our plan pays for	What you must pay and any additional requirements
	Dental services *(continued)*	
	limited to): • oral evaluations (examinations) • x-rays and other diagnostic imaging • dental cleaning (prophylaxis) • topical fluoride treatments • fillings • crowns • root canal therapy • scaling and root planing • complete and partial dentures • oral surgical procedures (to include extractions) • intravenous anesthesia/sedation (where medically necessary for oral surgical procedures) Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. **Some procedures may require prior authorization with documentation of medical necessity, including:** • Orthodontic services for members up to age 21 with adequate documentation of a handicapping malocclusion or medical necessity. • Dental treatment in an operating room or ambulatory surgical center. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	
	**Depression screening** We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0
	**Diabetes screening** We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Diabetes screening *(continued)*	
	• high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
	Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ◦ a blood glucose monitor ◦ blood glucose test strips ◦ lancet devices and lancets ◦ glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: ◦ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ◦ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. **Prior authorization is required for more than one blood glucose monitor per year and/or test strips in excess of 100 strips per 30 days. Prior authorization may be required for diabetic shoes and inserts. Prior authorization is the**	$0 **Notes:** • We exclusively cover OneTouch/LifeScan blood glucose monitors and test strips as our preferred diabetic supplies. Non-LifeScan monitors, and test strips may be covered if medically necessary, such as large font or talking meters for the visually impaired. You or your provider can request a medical exception, as a prior authorization is required. • Beginning January 2025, you must obtain your LifeScan blood glucose meter and other testing supplies (lancing devices, lancets and test strips) directly from a network pharmacy which requires a prescription from your provider. • Per CMS, some diabetic supplies under our exclusive partnership with LifeScan are covered under your medical coverage and will have a $0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Diabetic self-management training, services, and supplies *(continued)*	
	responsibility of your provider.	copay. Other diabetic supplies are not available through LifeScan and are covered under your prescription drug coverages. LifeScan diabetic supplies covered under your medical coverage such as meters and test strips are available at network pharmacies for $0 cost share. Diabetic supplies covered under your prescription drug coverage (alcohol swabs, lancets, 2x2 gauze, needles and syringes) can be found on your plan's formulary guide. • Continuous glucose monitors (CGMs) are considered durable medical equipment (DME).
	Doula Services We pay for the services of a doula. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula does not replace a licensed medical professional and cannot perform clinical tasks.	$0
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of your *Evidence of Coverage* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Durable medical equipment (DME) and related supplies *(continued)*	
	• diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and poles • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. Continuous glucose monitors (CGMs) and supplies are available through participating DME providers. For a list of DME providers, visit www.aetna.com/dsepublicContent/assets/pdf/en/DME_National_Provider_Listing.pdf. Dexcom and FreeStyle Libre continuous glucose monitors and supplies are also available at participating pharmacies. Your provider **must** obtain authorization for a continuous glucose monitor. Sensors can be obtained without prior authorization from the plan. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special-order it for you. The most recent list of participating pharmacies and suppliers is available on our website at AetnaBetterHealth.com/dsnp. **Prior authorization may be required and is the responsibility of your provider.**	
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) For members under 21 years of age, we pay for the following	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) *(continued)*	
	services: • well child care • preventive screenings • medical examinations • vision and hearing screenings and services • immunizations • lead screening • private duty nursing services We pay for private duty nursing for eligible EPSDT members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. **Prior authorization may be required and is the responsibility of your provider.**	
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part. • In the case of a pregnant woman in active labor, when: ◦ There is not enough time to safely transfer you to another hospital before delivery. ◦ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. In addition to Medicare-covered benefits, we also offer:	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan.
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Emergency care *(continued)*	
	• Emergency care (worldwide) • Emergency ambulance services (worldwide) When getting emergency care or ambulance services outside the United States, you may have to pay the provider at the time of service and submit for reimbursement.	
	Fall prevention You get a $150 annual benefit amount (allowance) to purchase approved home and bathroom safety products. These products can help you manage physical impairments and improve your ability to move around your home. To learn more about this benefit and order approved products, call **1-866-799-3832** (**TTY: 711**) Monday through Friday, 8 AM - 8 PM local time. Or you can visit CVS.com/benefits. Please note: • You cannot place more than 3 orders per year. • You cannot pay out-of-pocket if your purchase is above your benefit amount. • Products can only be purchased online or by phone. Products will be shipped directly to you, and you are responsible for any required assembly or installation.	$0
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Family planning services *(continued)*	
	• counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing **Services furnished by out-of-network providers are paid for directly by Medicaid.**	
	Fitness: Annual fitness membership You are covered for a basic membership to any SilverSneakers® participating fitness facility. If you do not reside near a participating facility, or prefer to exercise at home, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers. Included with your basic SilverSneakers membership, you will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self-help, and staying connected. These classes can be accessed online by visiting SilverSneakers.com. To get started, you will need your SilverSneakers ID number. Please visit SilverSneakers.com or call SilverSneakers at 1-855-627-3795 (**TTY:** 711) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Fitness: Annual fitness membership *(continued)*	
	found by using the SilverSneakers website or by calling SilverSneakers. Important: You get a basic membership at any participating SilverSneakers location. Facility amenities may vary by participating location including but not limited to hours, days and class types.	
	Health and wellness education programs • **24-Hour Nurse Line:** You can talk to a registered nurse 24 hours a day, 7 days a week on the 24/7 Nurse Line. They can help with health-related questions when your doctor is not available. Call **1-844-362-0934** (TTY: **711**). The registered nurse staff cannot diagnose, prescribe or give medical advice. If you need urgent or emergency care, call 911 and/or your doctor immediately.	$0
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We pay for the following services: • routine hearing exams • diagnostic hearing exams and balance exams • otologic and hearing aid examinations prior to prescribing hearing aids • hearing aids, as well as associated accessories and supplies • exams for the purpose of fitting hearing aids • follow-up exams and adjustments • repairs after warranty expiration	$0
	Help with Certain Chronic Conditions **Special Supplemental Benefits** Our plan offers additional benefits to members with qualifying chronic conditions. The information below describes eligibility criteria and the process for verifying eligibility.	$0
	This benefit is continued on the next page.	

Services that our plan pays for	What you must pay and any additional requirements
Help with certain chronic conditions *(continued)*	

Eligibility requirements:
If you are diagnosed with one or more of the chronic conditions listed below and meet certain criteria, you may be eligible for additional benefits under our plan to help manage your overall health and wellness. Enrollment in the plan does not guarantee eligibility. You will receive Special Supplemental Benefits after it is determined that you meet the eligibility requirements. However, you will not receive benefits for any time period before your eligibility was determined.
• Autoimmune disorders limited to:
  • Polyarteritis nodosa
  • Polymyalgia rheumatica
  • Polymyositis
  • Psoriasis
  • Rheumatoid arthritis
  • Systemic lupus erythematosus
• Cancer
• Cardiovascular disorders limited to:
  • Cardiac arrhythmias
  • Cardiac valve disease
  • Coronary artery disease
  • Peripheral vascular disease
  • Chronic venous thromboembolic disorder
• Chronic alcohol and other drug dependence
• Chronic and disabling mental health conditions limited to:
  • Anxiety
  • Bipolar disorders
  • Major depressive disorders
  • Paranoid disorder
  • Schizophrenia
  • Schizoaffective disorder
• Chronic heart failure
• Chronic lung disorders limited to:
  • Asthma
  • Chronic bronchitis
  • Chronic obstructive pulmonary disease (COPD)
  • Emphysema	

This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Help with certain chronic conditions *(continued)*	
	• Pulmonary fibrosis • Pulmonary hypertension • Dementia • Diabetes • End-stage liver disease • End-stage renal disease (ESRD) requiring dialysis • HIV/AIDS • Hyperlipidemia • Hypertension • Neurologic disorders limited to: • Amyotrophic lateral sclerosis (ALS) • Epilepsy • Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) • Huntington's disease • Multiple sclerosis (MS) • Parkinson's disease • Peripheral neuropathy • Polyneuropathy • Spinal stenosis • Stroke-related neurologic deficit • Severe hematologic disorders limited to: • Aplastic anemia • Chronic anemia • Hemophilia • Immune thrombocytopenic purpura • Myelodysplastic syndrome • Sickle-cell disease (excluding sickle-cell trait) • Chronic venous thromboembolic disorder • Stroke • Conditions that may cause cognitive impairment limited to: • Alzheimer's disease • Intellectual and developmental disabilities • Traumatic brain injuries • Disabling mental illness associated with cognitive impairment, and	
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Help with certain chronic conditions *(continued)*	
	• Mild cognitive impairment • Chronic pain • Overweight, Obesity, and Metabolic Syndrome • Osteoarthritis You can contact your Care Manager at 1-844-362-0934 (TTY: 711) 8 AM - 5 PM, Monday through Friday and they will work with you to determine your eligibility. **Extra Supports Wallet** After qualifying, the $240 monthly benefit amount in the Over-the-Counter (OTC) Wallet will change to the **Extra Supports Wallet with additional spending categories**. Qualifying members can use this wallet to help pay for: • Approved over-the-counter (OTC) health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. This benefit includes certain nicotine replacement therapies. ◦ Approved OTC products can be purchased in-store at participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at CVS.com/Aetna or by phone at 1-844-428-8147 (TTY:711). • Healthy foods including meat, produce, dairy products, and more ◦ Approved healthy food can be purchased in-store at participating retail stores and online at CVS.com/Aetna or by phone at 1-844-428-8147 (TTY:711). ◦ Examples of products that are not eligible include tobacco, alcohol, candy, soda, and non-food products. • Transportation including gas at the pump, public transportation, and certain ride share services ◦ Gas must be purchased at the pump by swiping the card and selecting credit as the payment type. ◦ The card cannot be used to purchase gas or products inside of a store at the gas station. ◦ Gas purchases are subject to holds and funds may be unavailable while that transaction is being processed.	
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Help with certain chronic conditions *(continued)*	
	◦ For ride share services, you will need to download the corresponding app and add the Aetna Medicare Extra Benefits Card as your payment type. • Utilities including gas, electric, water, sewer, landline, cell phone, and internet service ◦ The utility provider must accept Visa®. Utility expenses must be paid directly to the utility provider using the card. • Personal care products including paper towels, shampoo, soap, and more ◦ Approved personal care products can be purchased in-store at participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at CVS.com/Aetna or by phone at **1-844-428-8147** (TTY:**711**). Your eligibility for this wallet must be determined by the 15th day of the month in order to receive the benefit amount for that month. If eligibility is determined after the 15th day of the month, the benefit amount will be available the following month. Going forward for each month you are eligible, the benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each month. Be sure to use the full benefit amount each month, because any unused benefit amount will not roll over into the next month nor will it roll over into the next plan year. There are no exceptions to request additional or unused funds to be added to your card. This will replace your OTC Wallet. You will not get any additional funds applied to your card. **Important:** Aetna is not responsible for fees associated with late utility payments. For more information on the Aetna Medicare Extra Benefits Card, see the Aetna Medicare Extra Benefits Card section in Chapter 4. The benefits mentioned are a part of special supplemental program for the chronically ill. Eligibility is determined by whether you have a chronic condition associated with this benefit. Standards may vary for each benefit. Conditions include Hypertension, Hyperlipidemia, Diabetes, Cardiovascular Disorders, Cancer. Other eligible conditions may apply. Contact us to confirm your eligibility for these benefits.	

Services that our plan pays for	What you must pay and any additional requirements
HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies **Prior authorization may be required and is the responsibility of your provider.**	$0
Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but are not limited to:	$0
This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Home infusion therapy *(continued)*	
	• professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care The plan also covers certain durable medical equipment, as well as spiritual and grief counseling. For members under 21 years of age, both palliative and curative care are covered. **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to **Section E** of this chapter for more information. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:**	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Aetna Assure Premier Plus (HMO D-SNP). Hospice consultations are included as part of inpatient hospital care. Our plan covers all of your medical care not related to your terminal prognosis as it normally would.
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Hospice care *(continued)*	
	• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Evidence of Coverage.* **Note:** If you need non-hospice care, call your Care Manager and/or Member Services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Our plan covers all of your medical care not related to your terminal prognosis as it normally would. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	
	Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you are at risk and they meet Medicare Part B coverage rules The full childhood immunization schedule is covered for members under the age of 21. We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your *Evidence of Coverage* to learn more.	$0

Services that our plan pays for		What you must pay and any additional requirements
	Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse disorder treatment services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration • physician services	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Inpatient hospital care *(continued)*	
	Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available on the Web at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization may be required and is the responsibility of your provider.**	
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. We pay for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. The plan covers the following services: • inpatient services in a psychiatric hospital • services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital • Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting) **Prior authorization may be required and is the responsibility of your provider.**	$0
	Kidney disease services and supplies We pay for the following services:	$0
	This benefit is continued on the next page.	

	Services that our plan pays for	What you must pay and any additional requirements
	Kidney disease services and supplies *(continued)*	
	• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart. **Prior authorization may be required and is the responsibility of your provider.**	
	Lung cancer screening Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	$0

Services that our plan pays for		What you must pay and any additional requirements
	Managed Long Term Services and Supports (MLTSS) The MLTSS program provides Home- and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. This MLTSS program is available to members who meet certain clinical and financial requirements. MLTSS services include (but are not limited to): • assisted living services • cognitive, speech, occupational, and physical therapy • chore services • home-delivered meals • residential modifications (such as the installation of ramps or grab bars) • vehicle modifications • social adult day care • non-medical transportation **Prior authorization may be required and is the responsibility of your provider.**	$0
	Meal benefit (post-discharge) After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 14 freshly prepared meals for a 7-day period. These meals are provided to help support your recovery or manage your health conditions. We have teamed up with NationsMarket™ to provide this benefit. After we confirm your eligibility, NationsMarket will contact you to coordinate the delivery. **Note:** Observation and outpatient stays do not qualify you for this benefit. Meals must be scheduled for delivery within three months of the qualifying discharge as long as you are enrolled in the plan.	$0
	Medical day care This benefit is for people with physical and/or cognitive impairments.	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Medical day care *(continued)*	
	Our plan pays for preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. **Prior authorization may be required and is the responsibility of your provider.**	
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0
	Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:	$0 Part B drugs may be subject to step therapy requirements.
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Medicare Part B prescription drugs *(continued)*	
	• drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • the Alzheimer's drug, Leqembi (generic lecanemab) which is given intravenously (IV) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B does not cover them • osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it	
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Medicare Part B prescription drugs *(continued)*	
	• calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erthropoietin by injection if you have ESRD or you need this drug to treat anemia related to cetain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, MIcrera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link will take you to a list of Medicare Part B drugs that may be subject to step therapy: AetnaBetterHealth.com/new-jersey-hmosnp/providers/prior-authorization.html We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D prescription drug benefit. **Chapter 5** of your *Evidence of Coverage* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Evidence of Coverage* gives more information about the *Explanation of Benefits (EOB)* and how it helps you track your drug coverage. **Prior authorization may be required and is the responsibility of your provider.**	
	Nursing facility care A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not limited to, the following:	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Nursing facility care *(continued)*	
	• semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital. **Prior authorization may be required and is the responsibility of your provider.**	

Services that our plan pays for	What you must pay and any additional requirements
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use disorder counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing) **Prior authorization may be required and is the responsibility of your provider.**	$0
Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • other outpatient diagnostic tests **Prior authorization may be required and is the responsibility of your provider.**	$0

Services that our plan pays for		What you must pay and any additional requirements
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ◦ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” ◦ Sometimes you can be in the hospital overnight and still be “outpatient." ◦ You can get more information about being inpatient or outpatient in this fact sheet: medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. • labs and diagnostic tests billed by the hospital • mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • medical supplies, such as splints and casts • preventive screenings and services listed throughout the Benefits Chart • some drugs that you can’t give yourself **Prior authorization may be required and is the responsibility of your provider.**	$0
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Outpatient mental health care *(continued)*	
	• an Independent Practitioner Network or IPN (psychiatrist, psychologist, or Advanced Practice Nurse (APN)) Additionally, the plan covers the following services: • adult mental health rehabilitation (supervised group homes and apartments) • mental health outpatient (clinic/hospital services) • partial care and medication management **Prior authorization may be required and is the responsibility of your provider.**	
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
	Outpatient substance use disorder treatment services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment The plan covers substance use disorder screening, referrals, prescription drugs, and treatment of conditions. Covered services include, but are not limited to, the following:	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Outpatient substance use disorder treatment services *(continued)*	
	• non-medical detoxification/non-hospital based withdrawal management • substance use disorder short term residential • ambulatory withdrawal management with extended on-site monitoring/ambulatory detoxification • substance use disorder partial care • substance use disorder intensive outpatient • substance use disorder outpatient • opioid treatment services (methadone and non-methadone medication assisted treatment) • Refer to "Opioid treatment program (OTP) services" earlier in this chart for details. • Peer Recovery Support Services (PRSS) **Prior authorization may be required and is the responsibility of your provider.**	
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Over-the-Counter (OTC) Wallet You get an Over-the-Counter (OTC) Wallet with a $240 monthly benefit amount (allowance) on the Aetna Medicare Extra Benefits Card to pay for: • Approved over-the-counter (OTC) health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. This benefit includes certain nicotine replacement therapies. • Approved OTC products can be purchased in-store at participating retail stores including CVS® retail locations (excluding locations inside other stores) and online at CVS.com/Aetna or by phone at **1-844-428-8147** (TTY: **711**). Your monthly benefit amount will be available on the Aetna Medicare Extra Benefits Card the first day of each month. Be sure to use the full benefit amount each month, because any unused benefit amount will not roll over into the next month	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Over-the-Counter (OTC) Wallet *(continued)*	
	nor will it roll over into the next plan year. There are no exceptions to request additional or unused funds to be added to your card. **Important:** For more information on the Aetna Medicare Extra Benefits Card, see the Aetna Medicare Extra Benefits Card section in Chapter 4.	
	Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Personal Care Assistance (PCA) Covers health related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office	$0

Services that our plan pays for		What you must pay and any additional requirements
	Physician/provider services, including doctor's office visits *(continued)*	
	• certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes • evaluation of video and/or images you send to your doctor, interpretation, and follow-up by your doctor within 24 hours • consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to: ◦ surgery of the jaw or related structures ◦ setting fractures of the jaw or facial bones ◦ pulling teeth before radiation treatments of neoplastic cancer ◦ services that would be covered when provided by a physician **Prior authorization may be required and is the responsibility of your provider.**	

Services that our plan pays for		What you must pay and any additional requirements
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • routine exams	$0
	Private Duty Nursing (PDN) This benefit is for eligible beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. It is covered for MLTSS members of any age. **Prior authorization may be required and is the responsibility of your provider.**	$0
	Prostate cancer screening exams For men age 50 and over (and for men 40 and older with a family history of prostate cancer or other risk factors), we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
	Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but are not limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy)	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Prosthetic and orthotic devices and related supplies *(continued)*	
	We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details. **Prior authorization may be required and is the responsibility of your provider.**	
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
	Skilled nursing facility (SNF) care We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary	$0
	This benefit is continued on the next page.	

	Services that our plan pays for	What you must pay and any additional requirements
	Skilled nursing facility (SNF) care *(continued)*	
	• meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services • long-term (custodial) care in a nursing facility You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital **Prior authorization may be required and is the responsibility of your provider.**	
	Smoking and tobacco use cessation If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Smoking and tobacco use cessation *(continued)*	
	• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. The plan also covers over-the-counter (OTC) smoking cessation products, including nicotine gums, nicotine lozenges and nicotine patches.	
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0
	Transportation Medicaid Fee-for-Service directly covers non-emergency transportation. Covered services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage).	$0
	This benefit is continued on the next page.	

	Services that our plan pays for	What you must pay and any additional requirements
	Transportation *(continued)*	
	All non-emergency transportation is arranged through the state's transportation vendor, Modivcare. To schedule transportation, call Modivcare at 1-866-527-9933. You can also ask your PCP or Care Manager to help you to arrange this service. Please call your Care Manager and/or Member Services for more information at 1-844-362-0934. (TTY users should call **711**). Hours of operation are 8 AM to 8 PM, 7 days a week.	
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). In addition to Medicare-covered benefits, we also offer: • Urgent care (worldwide) When getting emergency care or ambulance services outside the United States, you may have to pay the provider at the time of service and submit for reimbursement.	$0
	Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye, including a comprehensive eye exam once per year for all members. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	Vision care *(continued)*	

	For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:
	• people with a family history of glaucoma
	• people with diabetes
	• African-Americans who are age 50 and over
	• Hispanic Americans who are 65 or over
	
	For all other members age 35 or older, a glaucoma screening is covered every five years.
	
	We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.
	
	If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.
	
	The plan also covers the following:
	• optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses
	• replacement lenses and frames (or contact lenses)
	  • once every 24 months for beneficiaries age 19 through 59, **or**
	  • once per year for beneficiaries 18 years of age or younger, **or**
	  • once per year for beneficiaries 60 years of age or older	

	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it	$0
	This benefit is continued on the next page.	

Services that our plan pays for		What you must pay and any additional requirements
	"Welcome to Medicare" preventive visit *(continued)*	
	Note: We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	
	Wigs for hair loss related to chemotherapy You get a $400 benefit amount (allowance) every year for covered wigs needed for hair loss due to chemotherapy. For assistance in purchasing a wig, please call Member Services at 1-844-362-0934 (TTY: **711**), 8 AM to 8 PM, 7 days a week.	$0

E. Benefits covered outside of our plan

We don't cover the following services, but they are available through NJ FamilyCare.

- Non-emergency transportation, including mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and delivery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). These services are paid for directly by Medicaid (also known as Medicaid Fee-for-Service).

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Evidence of Coverage.*

Note: If you need non-hospice care, call your Care Manager to arrange the services. Non-hospice care is care not related to your terminal prognosis.

F. Benefits not covered by our plan, Medicare, or NJ FamilyCare

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Evidence of Coverage*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

- services considered not "reasonable and medically necessary," according to Medicare and NJ FamilyCare standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines and as described in Chiropractic Services in the Benefits Chart in **Section D**
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic

foot disease
- radial keratotomy and LASIK surgery
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities.

Chapter 5: Getting your outpatient prescription drugs

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and NJ FamilyCare. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage.*
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to **Chapter 5**, **Section F** "If you are in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider that is providing care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription. Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs.* We call it the "*Formulary*" for short. (Refer to **Section B** of this chapter.)

- If it is not on the *List of Covered Drugs*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug. A **medically accepted indication** is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. Your drug may require approval from the plan based on certain rules before we will agree to cover it. See **Chapter 5, Section C**.

Table of Contents

Chapter 5 Getting your outpatient prescription drugs

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory,* visit our website or contact Member Services.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered prescription drug, or you can ask the pharmacy to look up your plan enrollment information.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Evidence of Coverage.*
- If you need help getting a prescription filled, contact Member Services.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory,* visit our website, or contact Member Services.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, look in the *Provider and Pharmacy Directory,* visit our website, or contact Member Services.

A6. Using mail-order services to get your drugs

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

Our plan's mail-order service allows you to order up to a 100-day supply.

Filling prescriptions by mail
To get order forms and information about filling your prescriptions by mail, visit our website (AetnaMedicare.com/NJDSNP) or contact Member Services.

Usually, a mail-order prescription arrives within 10 days. If the mail-order pharmacy expects the order to be delayed, they will notify you of the delay. If you need to request a rush order because of a mail-order delay, you may contact Member Services to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second-day or next-day delivery of your medications, you may request this from the Member Services representative for an additional charge.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by continuing to have your doctor send us your prescriptions. No special request is needed. Or you may contact Member Services to restart automatic deliveries if you previously stopped automatic deliveries.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by calling Member Services.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Member Services.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 15 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by logging on to your Caremark.com account or by calling Member Services.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Provide the pharmacy with your current mailing address, email address and/or phone number(s) and any special mailing instructions you may require.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *List of Covered Drugs*. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs.

You can also call Member Services for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail service pharmacy (including high-cost and unique drugs).
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

If you do need to go to an out-of-network pharmacy for any of the reasons listed above, the plan will cover up to a 10-day supply of drugs.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of your *Evidence of Coverage.*

B. Our plan's *List of Covered Drugs*

We have a *List of Covered Drugs*. We call it the "*Formulary*" for short.

We select the drugs on the *List of Covered Drugs* with the help of a team of doctors and pharmacists. The *List of Covered Drugs* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *List of Covered Drugs* when you follow the rules we explain in this chapter.

B1. Drugs on our *List of Covered Drugs*

Our *List of Covered Drugs* includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under NJ FamilyCare.

Our *List of Covered Drugs* includes brand name drugs, generic drugs, and biological products (which may

include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our List of Covered Drugs, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives that are called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *List of Covered Drugs*.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our *List of Covered Drugs*

To find out if a drug you take is on our *List of Covered Drugs*, you can:

- Visit our plan's website at AetnaMedicare.com/NJDSNP-drug-formulary. The *List of Covered Drugs* on our website is always the most current one.
- Call Member Services to find out if a drug is on our *List of Covered Drugs* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at Caremark.com or call Member Services. With this tool you can search for drugs on the *List of Covered Drugs* to get an estimate of what you will pay and if there are alternative drugs on the *List of Covered Drugs* that could treat the same condition.

B3. Drugs not on our *List of Covered Drugs*

We don't cover all prescription drugs. Some drugs are not on our *List of Covered Drugs* because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our *List of Covered Drugs*.

Our plan does not pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Evidence of Coverage* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and NJ FamilyCare drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.

3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or NJ FamilyCare cannot cover the types of drugs listed below.

- drugs used to promote fertility
- drugs used for the relief of cough or cold symptoms
- drugs used for cosmetic purposes or to promote hair growth
- prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- drugs used for the treatment of sexual or erectile dysfunction
- drugs used for the treatment of anorexia, weight loss or weight gain
- outpatient drugs made by a company that says you must have tests or services done only by them

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Evidence of Coverage*.

1. Limiting use of a brand name drug or original biological products when respectively, a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there is a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you respectively, the generic or interchangeable biosimilar version.

- We usually do not pay for the brand name drug or original biological product when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition will not work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. If

you don't get approval, we may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *List of Covered Drugs*. For the most up-to-date information, call Member Services or check our website at AetnaMedicare.com/NJDSNP-drug-formulary. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of the *Evidence of Coverage*.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *List of Covered Drugs*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our *List of Covered Drugs* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:

- is no longer on our *List of Covered Drugs* **or**
- was never on our *List of Covered Drugs* **or**
- is now limited in some way.

2. You must be in one of these situations:

- You were in our plan last year.
  - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You are new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - If you experience a change in your setting of care (such as being discharged or admitted to a long-term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with a temporary supply (at least a 30-day supply) for applicable drug(s).

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our *List of Covered Drugs* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our *List of Covered Drugs* or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Evidence of Coverage*.

If you need help asking for an exception, contact Member Services.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *List of Covered Drugs* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C.**

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *List of Covered Drugs* now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you are taking?
To get more information on what happens when our *List of Covered Drugs* changes, you can always:

- Check our current *List of Covered Drugs* online at AetnaMedicare.com/NJDSNP-drug-formulary **or**
- Call Member Services at the number at the bottom of the page to check our current *List of Covered Drugs*.

Changes we may make to the *List of Covered Drugs* that affect you during the current plan year
Some changes to the *List of Covered Drugs* will happen immediately: For example:

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *List of Covered Drugs* now. When that happens, we may remove the brand name drug and add the new generic

drug.
When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.
  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Evidence of Coverage* for more information on exceptions.
- **A drug is taken off the market**. If the FDA says a drug you are taking is not safe or effective or the drug's manufacturer takes a drug off the market, we may immediately take it off our *List of Covered Drugs*. If you are taking the drug, we will send you a notice after we make the change.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our *List of Covered Drugs*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our *List of Covered Drugs* **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our *List of Covered Drugs* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you have been taking. To learn more about asking for exceptions, refer to **Chapter 9** of your *Evidence of Coverage*.

Changes to the *List of Covered Drugs* that do not affect you during the current plan year
We may make changes to the drugs you take that are not described above and do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year.**

For example, if we remove a drug you are taking or limit its use, then the change does not affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you are taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We will not tell you above these types of changes directly during the current year. You will need to check the *List of Covered Drugs* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

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

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

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Evidence of Coverage* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to

- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services.

G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from certain pharmacies and/or from certain prescribers
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Evidence of Coverage*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and NJ FamilyCare (Medicaid) prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under NJ FamilyCare (Medicaid) .

Because you are eligible for NJ FamilyCare, you get "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage.*

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the "Drug List." It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at AetnaMedicare.com/NJDSNP-drug-formulary.
- **Chapter 5** of your *Evidence of Coverage.*
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5**, **Section B2**), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your Care Manager or Member Services for more information.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Evidence of Coverage* more information about network pharmacies.

Table of Contents

Chapter 6 What you pay for your Medicare and NJ FamilyCare (Medicaid) prescription drugs

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs.** This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits.* We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information.** This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under NJ FamilyCare. These drugs are included in the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:
- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of your *Evidence of Coverage.*

3. **Send us information about payments others have made for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

   When you get an EOB in the mail, make sure it is complete and correct.
   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call Aetna Assure Premier Plus (HMO D-SNP) Member Services or read the Aetna Assure Premier Plus (HMO D-SNP) *Evidence of Coverage*. You can access your *Evidence of Coverage* at our plan's website at AetnaMedicare.com/NJDSNP.

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Aetna Assure Premier Plus (HMO D-SNP) Member Services. You can also find answers to many questions on our website: AetnaMedicare.com/NJDSNP.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Aetna Assure Premier Plus (HMO D-SNP) Member Services.
- Or call Medicare at 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.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules. Refer to **Chapter 9** of the *Evidence of Coverage* to learn about how to file an appeal if you are told a drug will not be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of your *Evidence of Coverage* and our *Provider and Pharmacy Directory*.

C1. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Evidence of Coverage* or our *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers adult Medicare Part D vaccines at no cost to you.

D1. What you need to know before you get a vaccination

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination.

D2. What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you will pay nothing.

- For other Part D vaccines, you pay nothing for the vaccine.

2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you will pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay nothing for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 7 Asking us to pay a bill you got for covered services or drugs

A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow Aetna Assure Premier Plus (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to **Section B.**

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
  - If you paid for services covered by Medicare, we will pay you back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid for the Medicare service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services. **Call Member Services** at the number at the bottom of this page **if you get any bills.**

- Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of your *Evidence of Coverage* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

5. When you pay the prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (*Formulary*) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Evidence of Coverage*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Evidence of Coverage*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Evidence of Coverage.*

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records**.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (AetnaMedicare.com/NJDSNP), or you can call Member Services and ask for the form.

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

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 Assure Premier Plus (HMO D-SNP)
Aetna Duals COE Member Correspondence

PO Box 982980
El Paso, TX 79998

You must send your information to us within **12 months** of the date you received the service, item, or Part B drug.

For Part D prescription drug claims (including vaccines for preventing shingles or chicken pox): Mail your request for payment together with any bills or paid receipts to us at this address:

Aetna Assure Premier Plus (HMO D-SNP)
Aetna Integrated Pharmacy Solutions
PO Box 52446
Phoenix, AZ 85072

You must submit your claim to us within **36 months** of the date you got the Part D drug.

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug..

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay for it. If you already paid for the service or drug, we will mail you a check for what you

paid. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we will pay the provider directly.

Chapter 3 of your *Evidence of Coverage* explains the rules for getting your services covered.
Chapter 5 of your *Evidence of Coverage* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9.**

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal."

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Evidence of Coverage:*

- To make an appeal about a health care service, refer to **Section F**.
- To make an appeal about a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 8 Your rights and responsibilities

A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services at 1-844-362-0934 (TTY: **711**). Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English, including Spanish, and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services at 1-844-362-0934 (TTY: **711**) or write to:

  Aetna Duals COE Member Correspondence
  PO Box 982980
  El Paso, TX 79998

This document is available for free in Spanish.

Aetna Assure Premier Plus (HMO D-SNP) wants to make sure you understand your health plan information.

- If a different language or format works better for you, call Member Services at the number listed at the bottom of this page to request a change. (This is called a "standing request.")
- We will continue sending you mailings and other communications in your requested format.
- If you want to change your standing request for a preferred language or format, call Member Services.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- NJ Department of Human Services, Division of Medical Assistance & Health Services at **1-800-701-0710**. TTY users should call **711**
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

Debemos garantizar que todos los servicios se brinden de forma culturalmente competente y accesible. También debemos informarle sobre los beneficios del plan y sus derechos de una manera que usted pueda comprender. Debemos informarle sobre sus derechos cada año en los que forma parte de nuestro plan.

- Para obtener información de una manera que usted pueda comprender, llame al Departamento de Servicios para Miembros al 1-844-362-0934 (TTY: **711**). Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder preguntas en distintos idiomas.
- Nuestro plan también puede brindarle materiales en otros idiomas además del inglés, entre los que se incluyen español, y en formatos como tamaño de letra grande, braille o audio. Para obtener la documentación en uno de estos formatos alternativos, llame al Departamento de Servicios para Miembros al 1-844-362-0934 (TTY: **711**), o bien escríbanos a la siguiente dirección:

Aetna Duals COE Member Correspondence
PO Box 982980
El Paso, TX 79998

Este documento está disponible actualmente en español.

Aetna Assure Premier Plus (HMO D-SNP) quiere asegurarse de que comprende su información del plan de salud.

- Si le resulta más conveniente un idioma o formato diferente, llame al Departamento de Servicios para Miembros al número que figura en la parte interior de esta página para solicitar un cambio. (Esto se denomina "solicitud permanente").
- Si un idioma o formato diferente funciona mejor para usted, llame al Departamento de Servicios para Miembros al número que figura en la parte interior de esta página para solicitar un cambio. (Esto se denomina "solicitud permanente").
- Continuaremos enviando correspondencias y otras comunicaciones en su formato solicitado.
- Si quiere cambiar su solicitud permanente de un idioma o formato preferido, llame al Departamento de Servicios para Miembros. Si tiene problemas para obtener información sobre nuestro plan debido a problemas de idioma o una discapacidad, y quiere presentar un reclamo, llame a:
  - Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar durante las 24 horas, los 7 días de la semana. Los usuarios de TTY deben llamar al**1-877-486-2048**.
  - Departamento de Servicios Sociales de NJ, División de Asistencia Médica y Servicios de Salud al 1-800-701-0710. Los usuarios de TTY deben llamar al **711**
  - Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de TTY deben llamar al**1-800-537-7697**.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Evidence of Coverage*.
  - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- We do **not** require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Evidence of Coverage.*

Chapter 9 of your *Evidence of Coverage* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. Many documents are also available

in Spanish. We can also give you information in large print, braille, or audio, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Evidence of Coverage*) and drugs (refer to **Chapters 5 and 6** of your *Evidence of Coverage*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Evidence of Coverage*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Evidence of Coverage.*

F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Evidence of Coverage:*

- For more information about when you can join a new MA or prescription drug benefit plan.
- For information about how you will get your NJ FamilyCare benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Evidence of Coverage* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social

worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

Call Member Services for more information.

G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the state agency that oversees advance directives. To find the appropriate agency in your state, contact the SHIP program at **1-800-792-8820** (TTY: **711**). For more details about New Jersey State Health Insurance Assistance Program (SHIP), refer to **Chapter 2**.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of your *Evidence of Coverage* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Evidence of Coverage* – or you want more information about your rights, you can call:

- Member Services.
- The SHIP program at **1-800-792-8820** (TTY: **711**). For more details about the SHIP, refer to **Chapter 2, Section C**.
- The Ombudsperson Program at **1-800-446-7467**. For more details about this program, refer to **Chapter 2** of your *Evidence of Coverage*.

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).

You can also contact the New Jersey Medicaid program for assistance. You can call the NJ Department of Human Services, Division of Medical Assistance and Health Services at 1-800-701-0710 (TTY: **711**).

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Evidence of Coverage*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Evidence of Coverage*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Evidence of Coverage.*
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Evidence of Coverage* tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and NJ FamilyCare your new address when you move. Refer to **Chapter 2** of your *Evidence of Coverage* for phone numbers for Medicare and NJ FamilyCare.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- **Call Member Services for help if you have questions or concerns.**

J. Other rights and responsibilities under NJ FamilyCare

J1. Member responsibilities

You must:

- Provide, as much as possible, the information the professional staff needs to care for you
- Follow the instructions and guidelines given by your health care providers

J2. Member rights

You have the right:

- To be treated with respect, dignity, and need for privacy
- To be given information about the organization, its services, the practitioners providing care, and your rights and responsibilities
- To be able to communicate and be understood, with the help of a translator if you need one
- To choose your primary care practitioners (within the plan network) and the right to refuse care from specific practitioners
- To participate in making decisions about your health care
- To be fully informed by the Primary Care Practitioner, other health care provider, or Care Manager about your health and functional status, and to participate in developing a plan of care that promotes your functional abilities and encourages independence
- To voice any complaints about the organization or the care you get and to recommend changes in policies and services to plan staff, providers, and outside representatives of your choice. You have the right to do this free of restraint, interference, coercion, discrimination, or reprisal by the plan or its providers
- To prepare advance directives
- To access your medical records, following applicable Federal and State laws
- To be free from harm, including unnecessary physical restraints or isolation, too much medication, physical or mental abuse, or neglect
- To be free of hazardous procedures
- To receive information on available treatment options or alternative courses of care
- To refuse treatment and to be informed of the consequences of such refusal
- To have services provided that promote
  - a meaningful quality of life
  - independence
  - independent living in your home or another community setting as long as it is medically and socially possible
  - your natural support systems
- To choose or refuse health care in lieu of services or settings that the plan must provide, as long as the choices are medically appropriate and cost-effective.

J3. MLTSS member responsibilities

You must:

- Provide, as much as you can, the information needed by the professional staff that cares for you
- Follow the instructions and guidelines given by your health care providers
- Give all health and treatment-related information — including your medications, circumstances, living arrangements, and your support systems — to your Care Manager to identify your care needs and develop a plan of care
- Understand your health care needs and work with your Care Manager to set or change your goals and services and to create or modify your plan of care so you can get the services you need in a timely way
- Ask questions when you don't understand something
- Understand the risks associated with your decisions about care
- Tell your Care Manager about any significant changes to your health condition, medications, circumstances, living arrangements, or support systems
- Tell your Care Manager if any problems occur or if you are unhappy with the services you are getting
- Follow your health plan's rules and the rules of institutional or residential settings (including any applicable cost share)

J4. MLTSS member rights

You have the right:

- To request and receive information on the services available to you
- To have access to qualified service providers and the ability to choose between them
- To be informed of your rights before you get approved services that you have chosen
- To receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability
- As a resident of an MLTSS community, you have the right to:
  - have a key to lock/unlock the home and bedroom doors
  - have visitors of your choosing
  - make and receive phone calls
  - make an independent schedule
  - have access to food at any time unless otherwise determined in a documented, person-centered process
  - have access to appropriate services that support your health and welfare
- To assume risk after being fully informed and able to understand the risks and results of the decisions made
- To make decisions about your care needs
- Participate in developing your plan of care and making changes to it
- Request service changes at any time, including adding, increasing, decreasing, or discontinuing
- Request and receive from your Care Manager a list of names and duties of any person(s) who provides services to you under the plan of care
- Receive support and direction from your Care Manager to resolve concerns about your care needs

or complaints about services or providers
- Be informed of and receive in writing facility-specific resident rights when you are admitted to an institutional or residential setting
- Be informed of all the covered/required services you are entitled to, required by or offered by the institutional or residential setting, and any facility charges not covered by the managed care plan
- Not be transferred or discharged out of a facility except:
  - for medical necessity
  - to protect your physical welfare and safety or the welfare and safety of other residents
  - because of failure, after reasonable and appropriate notice, of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment
- Have your health plan protect and promote your ability to exercise all rights identified in this document
- Have all the rights and responsibilities outlined here sent to your authorized representative or court-appointed legal guardian

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

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation**.

Table of Contents

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

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- "Making a complaint" instead of "filing a grievance"
- "Coverage decision" instead of "organization determination," "benefit determination," "at-risk determination," or "coverage determination"
- "Fast coverage decision" instead of "expedited determination"
- "Independent Review Organization" (IRO) instead of "Independent Review Entity" (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it's confusing to start or follow the process for dealing with a problem. This can be especially true if you don't feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the New Jersey State Health Insurance Assistance Program (SHIP)

You can call the SHIP. The SHIP counselors can answer your questions and help you understand what to do about your problem. The SHIP is not connected with us or with any insurance company or health plan. The SHIP has trained counselors in every county, and services are free. The SHIP phone number is **1-800-792-8820** (TTY: **711**).

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

- Visit the Medicare website (www.medicare.gov).

Help and information from the NJ Department of Human Services, Division of Medical Assistance and Health Services (the New Jersey Medicaid program)

You can get help and information from the Division of Medical Assistance & Health Services (the New Jersey Medicaid program) by calling **1-800-701-0710** (TTY: **711**). Their website can be found at state.nj.us/humanservices/dmahs/.

C. Understanding Medicare and NJ FamilyCare complaints and appeals in our plan

You have Medicare and NJ FamilyCare. Information in this chapter applies to **all** of your Medicare and NJ FamilyCare benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and NJ FamilyCare processes.

Sometimes Medicare and NJ FamilyCare processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a NJ FamilyCare benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E**, "Coverage decisions and appeals."	**No.** My problem is not about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B prescription drugs as **medical care**.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section F** of your *Evidence of Coverage*).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you. In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or NJ FamilyCare. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- The New Jersey State Health Insurance Assistance Program (SHIP), which can be reached at **1-800-792-8820** (TTY: **711**).

- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F,** "Medical care"
- **Section G,** "Medicare Part D prescription drugs"
- **Section H,** "Asking us to cover a longer hospital stay"
- **Section I,** "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page. You can also get help or information from government organizations such as your SHIP program at **1-800-792-8820** (TTY: **711**).

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care that is described in **Chapter 4** of your *Evidence of Coverage*. In some cases, different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prespricption drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but are not getting.
   What you can do: You can ask us to make a coverage decision. Refer to **Section F2.**
2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.
   What you can do: You can appeal our decision. Refer to **Section F3.**
3. You got medical care that you think we cover, but we will not pay.
   What you can do: You can appeal our decision not to pay. Refer to **Section F5.**
4. You got and paid for medical care you thought we cover, and you want us to pay you back.
   What you can do: You can ask us to pay you back. Refer to **Section F5**.
5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.
   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4.**
   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an ***'integrated organization determination."***

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-844-362-0934 (TTY: **711**).
- Faxing: 1-833-322-0034.
- Writing:
  Aetna Assure Premier Plus (HMO D-SNP)
  PO Box 818051.
  Cleveland, OH 44181-8051

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For

more information about making a complaint, including a fast complaint, refer to **Section K.**

Fast coverage decision

The legal term for "fast coverage decision" is **"expedited determination."**

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical items and/or services that you **did not get.** You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 1-844-362-0934 (TTY: **711**).

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-844-362-0934 (TTY: **711**).

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.
- We can accept an appeal request 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:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

- We automatically give you a fast appeal if your doctor asks for it.
- How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K.**

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal.** We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options.
- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a NJ FamilyCare service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, NJ FamilyCare, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that NJ FamilyCare usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and NJ FamilyCare** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the

service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by NJ FamilyCare, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE."**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The IRO can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The IRO take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 IRO's decision for **standard requests, or**

- Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**

- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and NJ FamilyCare

A Level 2 Appeal for services that NJ FamilyCare usually covers gives you two options. One option is an appeal with the IURO, the state's Independent Utilization Review Organization. The second option is a Fair Hearing with the state. You must request an IURO appeal **within 60 calendar days** of the date we sent the decision letter on your Level 1 Appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

How do I request an IURO appeal?

- The Independent Utilization Review Organization (IURO) is an independent organization that is hired by the State of New Jersey's Department of Banking and Insurance (DOBI). This organization is not connected with us, and it is not a government agency. This organization is chosen by the DOBI to serve as an independent reviewer for medical appeals, and the DOBI administers the IURO appeal process. A review by the IURO is also sometimes called an "IURO appeal" or an "External Appeal."
- The IURO will typically not review cases based on the following services:
  - assisted living program
  - assisted living services - when the denial is not based on medical necessity
  - caregiver/participant training
  - chore services
  - community transition services
  - home based supportive care
  - home-delivered meals
  - personal care assistance (PCA)
  - respite (daily and hourly)

  - social day care
  - structured day program -- when the denial is not based on medical necessity
  - supported day services -- when the denial is not based on the diagnosis of TBI
- The IURO appeal process is optional. You can request an IURO appeal, and wait to receive the IURO's decision, before you request a Fair Hearing. Or, you can request an IURO appeal and a Fair Hearing at the same time (the requests are made to two different organizations). **You are not required to request an IURO appeal before requesting a Fair Hearing.**
- You can request an IURO appeal yourself, or it can be requested by your authorized representative (which includes your provider, if they are acting on your behalf with your written consent).
- You can request an IURO appeal by filling out the *External Appeal Application* form. A copy of the *External Appeal Application* form will be sent to you with the decision letter for your Level 1 Appeal. You must send this form to the following address **within 60 calendar days** of the date on the decision letter for your Level 1 appeal:

Maximus Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, New York 14534

You may also fax the form to **585-425-5296**, or email a copy of the form to Stateappealseast@maximus.com.

- If you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your IURO appeal, you must request the IURO appeal **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.
- If the IURO reviews your case, it will reach a decision **within 45 calendar days** (or sooner, if your medical condition makes it necessary). If your IURO appeal is a "fast" appeal, the IURO will reach a decision **within 48 hours**.
- If you have questions about the IURO appeal process and/or need assistance with your application, you can call the New Jersey Department of Banking and Insurance at 1-888-393-1062 or 609-777-9470.

How do I request a Fair Hearing?

- You must ask for a Fair Hearing in writing **within 120 calendar days** of the date that we sent the decision letter on your Level 1 Appeal. The letter you get from us will tell you where to submit your hearing request.
- If you ask for an expedited, or "fast" Fair Hearing, and you meet all of the requirements for a "fast" hearing, a decision will be made within 72 hours of the agency's receipt of your hearing request.
- However, if you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your Fair Hearing, you must request that your benefits be continued **in writing** on your Fair Hearing request, and you must send your request **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.

Or, if you asked for an IURO appeal and received an adverse decision before requesting a Fair Hearing, you must send this written request **within 10 calendar days** of the date on the letter informing you of the adverse decision on your IURO appeal.

Please note that if you ask to have your services or items continue during a Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of the services or items.

The Fair Hearing office gives you their decision in writing and explains the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or items.

For more information, refer to **Chapter 7** of your *Evidence of Coverage*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.

- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in **Section F3.** When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and NJ FamilyCare usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4**, for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that NJ FamilyCare may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Evidence of Coverage* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that is not on our plan's *List of Covered Drugs* or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's List of Covered Drugs but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our *List of Covered Drugs* or need us to set aside a rule or restriction on a drug we cover. **You can ask us to make an exception.** (This is a type of coverage decision.) Start with **Section G2,** then refer to **Sections G3 and G4.**	You want us to cover a drug on our *List of Covered Drugs*, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. **You can ask us for a coverage decision.** Refer to **Section G4.**	You want to ask us to pay you back for a drug you already got and paid for. **You can ask us to pay you back.** (This is a type of coverage decision.) Refer to **Section G4.**	We told you that we won't cover or pay for a drug in the way that you want. **You can make an appeal.** (This means you ask us to reconsider.) Refer to **Section G5.**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our *List of Covered Drugs* or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug that is not on our *List of Covered Drugs*

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *List of Covered Drugs* (refer to **Chapter 5** of

your *Evidence of Coverage* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- Our *List of Covered Drugs* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *List of Covered Drugs* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No.**

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

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-844-362-0934 (TTY: **711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Evidence of Coverage.*
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K.**

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get

your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard** or **fast appeal** by calling 1-844-362-0934 (TTY: **711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought within **30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE."**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file." **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals

process, you:
- Decide if you want to make a Level 3 Appeal.
- Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Evidence of Coverage.*

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged. You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In New Jersey, the QIO is Livanta. Call them at **1-866-815-5440** (TTY: **711**). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2.**

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you do not call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**).

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-866-815-5440** (TTY: **711**).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and

make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**).
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Evidence of Coverage* for more information

about the QIO and how to contact them.
- Ask them to review your appeal and decide whether to change our plan's decision.

- **Act quickly and ask for a "fast-track appeal."** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage."**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-866-815-5440** (TTY: **711**).

You must ask for this review within **60 calendar days** after the day the QIO said **No** to your Level 1 Appeal.

You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.

  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional NJ FamilyCare appeals

You may also have other appeal rights if your appeal is about services or items that NJ FamilyCare usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

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

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.

Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Member Services at 1-844-362-0934 (TTY: **711**).

The legal term for a "complaint" is a ***"grievance."***

The legal term for "making a complaint" is ***"filing a grievance."***

K2. Internal complaints

To make an internal complaint, call Member Services at 1-844-362-0934 (TTY: **711**). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- To file a grievance (complaint) in writing, send us your written complaint to
  Appeals and Grievances
  PO Box 818070
  Cleveland, OH 44181
  - Please be sure you provide all pertinent information, including any supporting documents you believe are appropriate.
  - Your issue will be investigated by a member of our complaint team. If you submit your complaint verbally or in writing, we will inform you the result of our review in writing. Our notice will include a description of our understanding of your complaint and our resolution 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; or
- Our denial of your request to expedite a coverage determination or redetermination (appeal) for a prescription drug.

The legal term for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx. You do not need to file a complaint with Aetna Assure Premier Plus (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.You can also contact the state's Medicaid program with a complaint by calling the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) at 1-800-701-0710 (TTY: 711).

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Linda Colón, Regional Manager
Office for Civil Rights

U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Customer Response Center: 1-800-368-1019
Fax: 1-202-619-3818
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA) and under the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason. If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697) or your local Office for Civil Rights. You can also contact and review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index. If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Evidence of Coverage*.

In New Jersey, the QIO is called Livanta. The phone number for Livanta is **1-866-815-5440** (TTY: **711**).

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and NJ FamilyCare (Medicaid) programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 10 Ending your membership in our plan

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have NJ FamilyCare, you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period,** which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for NJ FamilyCare or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1.**
- Medicaid services in **Section C2.**

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- The State Health Insurance Assistance Program (SHIP), at **1-800-792-8820** (TTY: **711**).

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of your *Evidence of Coverage* for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two

ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call **1-877-486-2048**. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C1**.

C. How to get Medicare and NJ FamilyCare services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP)	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**). **OR** Enroll in a new integrated D-SNP plan directly, or through a broker or agent contracted with the new D-SNP plan. You will automatically be disenrolled from our plan when your coverage with the new D-SNP plan begins. Your NJ FamilyCare (Medicaid) coverage will also be shifted to the new D-SNP, and will be covered through that new plan.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**). **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our plan when your Original Medicare coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another dual eligible special needs plan (D-SNP) plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: **711**).

3. You can change to:	**Here is what to do:**
Original Medicare without a separate Medicare prescription drug plan **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**), Monday through Friday from 8:30 a.m. to 4:30 p.m. For more information or to find a local New Jersey State Health Insurance Assistance Program (SHIP) office in your area, please visit nj.gov/humanservices/doas/services/q-z/ship/index.shtml	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**) You are automatically disenrolled from our plan when your Original Medicare coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another dual eligible special needs plan (D-SNP) plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: **711**).

4. You can change to:	**Here is what to do:**
Any Medicare health plan during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A**.**	Call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the New Jersey State Health Insurance Assistance Program (SHIP) at **1-800-792-8820** (TTY: **711**) **OR** Enroll in a new Medicare plan You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey, for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another dual eligible special needs plan (D-SNP) plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: **711**).

C2. Your NJ FamilyCare services

If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Aetna Better Health of New Jersey for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: **711**).

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Aetna Assure Premier Plus (HMO D-SNP) ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
  - Our plan will continue to cover your Medicare benefits for a grace period of up to three months if you lose Medicaid eligibility. This grace period begins the first day of the month after we learn of your loss of eligibility and communicate that to you. If at the end of the three-month grace period you have not regained Medicaid and you have not enrolled in a different plan, we will disenroll you from our plan and you will be enrolled back in Original Medicare.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) will notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

If you are within our plan's three-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, Medicaid-only benefits may not be covered by our plan. To find out if a benefit is Medicaid-only, and/or to find out if it will be covered, you can call Aetna Assure Premier Plus (HMO D-SNP) at 1-844-362-0934 (TTY: **711**). All of your Medicare services, including Medicare Part D prescription drugs, will continue to be covered at $0 cost sharing (no copayments, coinsurance, or deductibles) during the period of deemed continued eligibility.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical

care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Evidence of Coverage* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

Chapter 11 Legal notices

A. Notice about laws

Many laws apply to this *Evidence of Coverage.* These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Evidence of Coverage.* The main laws that apply are federal laws about the Medicare and NJ FamilyCare (Medicaid) programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights. You can reach the New Jersey Division on Civil Rights at 1-833-653-2748 (TTY: **711**), and you can learn how to file a complaint online at https://www.njoag.gov/about/divisions-and-offices/division-on-civil-rights-home/division-on-civil-rights-file-a-complaint/.
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and NJ FamilyCare as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that NJ FamilyCare is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Evidence of Coverage* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services at the number at the bottom of this page.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Evidence of Coverage* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without getting a new prescription. (See "Interchangeable Biosimilar").

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care Manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Evidence of Coverage* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services. **Chapter 9** of your *Evidence of Coverage* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

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

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicare. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

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

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded services: Services that are not covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

***Evidence of Coverage* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. A FIDE SNP covers both Medicare and Medicaid under a single health plan. Our plan is a FIDE SNP.

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

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 (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you for services. Call Member Services if you get any bills you don't understand. Because we pay the entire cost for your services, you do not owe any cost sharing. Providers should **not** bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity.**

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

***List of Covered Drugs* (*Formulary*):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *List of Covered Drugs* tells you if there are any rules you need to follow to get your drugs. The *List of Covered Drugs* is sometimes called a "formulary."

Low Income Subsidy (LIS): Refer to "Extra Help."

Managed Long-term services and supports (MLTSS): Managed Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. MLTSS includes Community-based Services and Nursing Facilities (NF).

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA," that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA," that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare prescription drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

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

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Evidence of Coverage* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

NJ FamilyCare: This is the name of New Jersey Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of your *Evidence of Coverage*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, make a decision about whether services are covered. Organization determinations are called "coverage decisions." **Chapter 9** of your *Evidence of Coverage* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Evidence of Coverage* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Evidence of Coverage* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Evidence of Coverage*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted our plan website.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Evidence of Coverage* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes alternative drugs that may be used for the same health condition as a given drug and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. You can find more information about referrals in **Chapters 3 and 4** of your *Evidence of Coverage*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Evidence of Coverage* to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Fair Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Fair Hearing. If the State Fair Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you cannot get to them because given your time, place, or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).

Aetna Assure Premier Plus (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	1-844-362-0934 (TTY: 711) Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. 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 8 PM, 7 days a week.
FAX	1-855-259-2087
WRITE	Aetna Assure Premier Plus (HMO D-SNP) Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	Go to AetnaMedicare.com/NJDSNP or scan this code with your smartphone to visit our website.

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:

CALL	1-800-792-8820 Monday–Friday 8:30 AM to 4:30 PM
TTY	711
WRITE	NJ State Health Insurance Assistance Program, Division of Aging Services, PO Box 807, Trenton, NJ 08625
WEBSITE	nj.gov/humanservices/doas/services/q-z/ship/index.shtml

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