aetna®

AETNA BETTER HEALTH℠ FIDA PLAN

2017 Participant Handbook

Aetna Better Health FIDA plan is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

www.aetnabetterhealth.com/newyork

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Helpful information

Participant Services
1-855-494-9945 (TTY: 711)

Non-Emergency Transportation
1-866-334-8919

Address
Aetna Better Health FIDA Plan
55 W. 125th St., Suite 1300
New York, NY 10027

Personal information

My ID number

My PCP (primary care provider)

My PCP's phone number

My care manager's name and phone number

Aetna Better Health FIDA Plan

Participant Handbook

January 1, 2017 – December 31, 2017

Your Health and Drug Coverage under Aetna Better Health FIDA Plan

This handbook tells you about your coverage under Aetna Better Health FIDA Plan (Medicare-Medicaid Plan) from the date you are enrolled with Aetna Better Health FIDA Plan through December 31, 2017. It explains how Aetna Better Health FIDA Plan covers Medicare and Medicaid services, including prescription drug coverage, at no cost to you. It explains the health care services, behavioral health services, prescription drugs, and long-term services and supports that Aetna Better Health FIDA Plan covers. Long-term services and supports include long-term facility-based care and long-term community-based services and supports. Long-term community-based services and supports provide the care you need at home and in your community, and can help reduce your chances of going to a nursing facility or hospital.

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

Aetna Better Health FIDA Plan is a Fully Integrated Duals Advantage (FIDA) Plan that is offered by Aetna Better Health of New York. When this *Participant Handbook* says "we," "us," or "our," it means Aetna Better Health of New York. When it says "the plan" or "our plan," it means Aetna Better Health FIDA Plan.

You can get this handbook for free in other languages. Call 1-855-494-9945 (TTY: **711**), 24 hours a day, 7 days a week. The call is free.

Puede recibir esta información en otros idiomas en forma gratuita. Llame al **1-855-494-9945** o al **711** (línea TTY/TDD), las 24 horas del día, los 7 días de la semana. Esta llamada es gratuita.

È possibile ottenere queste informazioni gratuitamente in alter lingue. Chiamare il numero **1-855-494-9945** e il número **711** per il servizio TTY/TDD per I non udenti, 24 ore al giorno 7 giorno alla settimana. La chiamata è gratuita.

Ou kapab jwenn enfòmasyon saa pou gratis nan lòt lang. Rele **1-855-494-9945** ak **711** pou TTY/TDD, 24 èd tan chak jou, 7 jou pasemèn. Apèl la gratis.

┌可以免費取得本資訊的其他語言版本。請撥打 **1-855-494-9945**，若使用 TTY/TDD 請撥 **711**，每週 7 天、每天 24 小時均提供服務。此┌免費電話。

Вы можете бесплатно получить эту информацию в переводе на другой язык. Позвоните по телефону **1-855-494-9945**. Линия работает круглосуточно и без выходных. Звонки бесплатные. Если вы пользуетесь устройством TTY/TDD, звоните по телефону **711**.

If you have questions, please call Aetna Better Health FIDA Plan at 1-855-494-9945 (TTY: 711), 24 hours a day, 7 days a week. The call is free. For more information, visit www.aetnabetterhealth.com/newyork.

다른 언어로 이 정보를 무료로 받으실 수 있습니다.연중 무휴 24 시간 **1-855-494-9945** 번 또는 TTY/TDD 의 경우 **711** 번으로 전화해 주십시오. 통화는 무료입니다.

You can get this handbook for free in other formats, such as large print, braille, or audio. Call **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

A care manager will call you after you become a participant of Aetna Better Health FIDA Plan. During this call they will ask if you have a preferred language and/or format to receive plan information. You can also contact Participant Services or your care manager to change your preference at any time.

Disclaimers

Aetna Better Health FIDA Plan is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

Limitations and restrictions may apply. For more information, call Aetna Better Health FIDA Plan Participant Services or read the Aetna Better Health FIDA Plan Participant Handbook. This means that you need to follow certain rules to have Aetna Better Health FIDA Plan pay for your services.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by Aetna Better Health FIDA Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Chapter 1: Getting started as a Participant

Table of Contents

A. Welcome to Aetna Better Health Premier Plan

Aetna Better Health FIDA Plan is a Fully Integrated Duals Advantage (FIDA) Plan. A *FIDA Plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Care Managers and Interdisciplinary Teams (IDTs) to help you manage all your providers and services. They all work together to provide the care you need.

Aetna Better Health FIDA Plan was approved by New York State and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the FIDA Demonstration.

FIDA is a demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services. At present, this demonstration is scheduled to last until December 31, 2017.

Aetna Better Health of New York has been serving Managed Long Term Care (MLTC) members in New York since 2011. Our parent company, Aetna has more than 30 years of managing care for people enrolled in Medicaid and Medicare. We understand the needs of our participants. We will work with local New York providers and community groups to meet those needs.

B. What are Medicare and Medicaid?

Medicare

Medicare is the federal health insurance program for:

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

Medicaid

Medicaid is a program run by the federal government and New York State that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides what counts as income and resources and who qualifies. Each state also decides which 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 New York State must approve Aetna Better Health FIDA Plan each year. You can get Medicare and Medicaid services through our plan as long as:

- You are eligible to participate in the FIDA Demonstration,
- We choose to offer the FIDA Plan, and
- Medicare and New York State approve Aetna Better Health FIDA Plan to participate in the FIDA Demonstration.

If at any time our plan stops operating, your eligibility for Medicare and Medicaid services will not be affected.

C. What are the advantages of this FIDA Plan?

In the FIDA Demonstration, you will get all your covered Medicare and Medicaid services from Aetna Better Health FIDA Plan, including long-term services and supports (LTSS) and prescription drugs. You do not pay anything to join or get services from this plan. However, if you have Medicaid with a "spend-down" or "excess income," you will have to continue to pay your spend-down to the FIDA Plan.

Aetna Better Health FIDA Plan will help make your Medicare and Medicaid benefits work better together and work better for you. Here are some of the advantages of having Aetna Better Health FIDA Plan:

- You will have an Interdisciplinary Team that you help put together. An Interdisciplinary Team (IDT) is a group of people that will get to know your needs and work with you to develop and carry out a Person-Centered Service Plan specific to your needs. Your IDT may include a Care Manager, doctors, service providers, or other health professionals who are there to help you get the care you need.
- You will have a Care Manager. This is a person who works with you, with Aetna Better Health FIDA Plan, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your IDT and your Care Manager.
- The IDT and Care Manager will work with you to come up with a Person-Centered Service Plan specifically designed to meet your needs. The IDT will be in charge of coordinating the services you need. This means, for example:
  - » Your IDT will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - » Your IDT will make sure your test results are shared with all your doctors and other providers.
  - » Your IDT will help you schedule and get to appointments with doctors and other providers.

D. What is Aetna Better Health FIDA Plan's service area?

Our service area includes these counties in New York: Kings, Nassau, New York, Queens and Suffolk.

Only people who live in our service area can join Aetna Better Health FIDA Plan.

If you move outside of our service area, you cannot stay in this plan.

E. What makes you eligible to be a plan Participant?

You are eligible for our plan as long as:

- you live in our service area;
- you are entitled to Medicare Part A, enrolled in Medicare Part B, and eligible for Medicare Part D;
- you are eligible for Medicaid;
- you are a United States citizen or are lawfully present in the United States;
- you are age 21 or older at the time of enrollment;
- you require 120 or more days of community-based or facility-based LTSS or are nursing facility clinically eligible and get facility-based long-term support services; and
- you are not excluded from enrollment based on one of the exclusions listed below.

You will be excluded from joining our plan if:

- you are a resident of a New York State Office of Mental Health (OMH) facility or a psychiatric facility;
- you are getting services from the State Office for People with Developmental Disabilities (OPWDD) system – whether getting services in an OPWDD facility or treatment center, getting services through an OPWDD Waiver, whether you could be getting services in an ICF/IID but you have chosen not to, or otherwise;
- you are expected to be Medicaid eligible for less than six months;
- you are eligible for Medicaid benefits only for tuberculosis related services, breast cancer services, or cervical cancer services;
- you are getting hospice services (at time of enrollment);
- you are eligible for the family planning expansion program;
- you are a resident of an alcohol/substance abuse long-term residential treatment program;
- you are eligible for Emergency Medicaid;
- you are enrolled in the 1915(c) waiver program for Traumatic Brain Injury (TBI);
- you participate in and reside in an Assisted Living Program; or
- you are in the Foster Family Care Demonstration.

If you have questions, please call Aetna Better Health FIDA Plan at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/newyork**.

F. What to expect when you first join a FIDA Plan

When you first join the plan, you will get a comprehensive assessment of your needs within the first 90 days or within six months of your last assessment if you joined Aetna Better Health FIDA Plan from Aetna Better Health of New York. The assessment will be conducted by a Registered Nurse from Aetna Better Health FIDA Plan.

If Aetna Better Health FIDA Plan is new for you, you can keep seeing the doctors you go to now and getting your current services for a certain amount of time. This is called the "transition period." In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later.

After the transition period, you will need to see doctors and other providers in the Aetna Better Health FIDA Plan network. *A network provider is a provider who works with Aetna Better Health FIDA Plan.* See Chapter 3 for more information on getting care.

There are two exceptions to the transition period described above:

- If you are a resident of a nursing facility, you can continue to live in that nursing facility for the duration of the FIDA Demonstration, even if the nursing facility does not participate in Aetna Better Health FIDA Plan's network.
- If you are getting services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in Aetna Better Health FIDA Plan's network.

G. What is a Person-Centered Service Plan?

Within the first 90 days after your enrollment effective date, you will meet with the members of your Interdisciplinary Team (IDT) to talk about your needs and develop your Person-Centered Service Plan (PCSP). A PCSP is the plan for what health services, long-term services and supports, and prescription drugs you will get and how you will get them.

You will have a comprehensive re-assessment when necessary, but at least every six months. Within 30 days of the comprehensive re-assessment, your IDT will work with you to update your PCSP. At any time, you may ask for a new assessment or an update to your PCSP by calling your Care Manager.

H. Does Aetna Better Health FIDA Plan have a monthly plan premium?

No. There is no monthly plan premium and there are no other costs for participating in Aetna Better Health FIDA Plan. However, if you have Medicaid with a "spend-down" or "excess income," you will have to continue to pay your spend-down to the FIDA Plan.

I. About the Participant Handbook

This *Participant Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, call 1-800-MEDICARE (1-800-633-4227), or call the Independent Consumer Advocacy Network at 1-844-614-8800. You may also complain about the quality of the services we provide by calling Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

The contract is in effect for the months you are enrolled in Aetna Better Health FIDA Plan between January 1, 2017 and December 31, 2017.

J. What other information will you get from us?

You should have already gotten an Aetna Better Health FIDA Plan Participant ID Card, a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

Your Aetna Better Health FIDA Plan Participant ID Card

Under our plan, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:

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

As long as you are a Participant of our plan, you do not need to use your red, white, and blue Medicare card or your Medicaid card to get services. Keep those cards in a safe place, in case you need them later.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* is a list of the providers and pharmacies in the Aetna Better Health FIDA Plan network. While you are a Participant of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 7). There are also some exceptions if you cannot find a provider in our plan who can meet your needs. You will need to discuss this with your Interdisciplinary Team (IDT).

- You can ask for an annual *Provider and Pharmacy Directory* by calling Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. You can also see the *Provider and Pharmacy Directory* at **www.aetnabetterhealth.com/newyork** or download it from this website.
- The Provider & Pharmacy Directory gives you information on how to obtain care and lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support providers (such as Adult Day Health and Home Health providers) that you may see as an Aetna Better Health FIDA Plan member. It also lists the pharmacies that you may use to get your prescription drugs.

What are "network providers"?

- Aetna Better Health FIDA Plan's network providers include:
  - Doctors, nurses, and other health care professionals that you can go to as a Participant of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; and
  - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.
- Network providers have agreed to accept payment from our plan for covered services as payment in full. By seeing these providers, you will not have to pay anything for covered services.

What are "network pharmacies"?

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan Participants. 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. There are no costs to you when you get prescriptions from network pharmacies.

Call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week for more information. Both Participant Services and Aetna Better Health FIDA Plan's website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Aetna Better Health FIDA Plan.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit **www.aetnabetterhealth.com/newyork** or call **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

The Explanation of Benefits

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

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

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Participant Services.

K. How can you keep your Participant record up to date?

You can keep your Participant record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your Participant record to know what services and drugs you get.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing facility or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8.

Chapter 2: Important phone numbers and resources

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A. How to contact Aetna Better Health FIDA Plan Participant Services

CALL	**1-855-494-9945** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week
WRITE	Aetna Better Health FIDA Plan 55 West 125th Street, Suite 1300 New York, NY 10027
WEBSITE	**www.aetnabetterhealth.com/newyork**

Contact Participant Services about:

- **Questions about the plan**
- **Questions about claims, billing or Participant ID Cards**
- **Coverage decisions about your services and items**

  A coverage decision is a decision about whether you can get certain covered services and items or how much you can have of certain covered services and items.

  Call us or your Care Manager if you have questions about a coverage decision Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) made about your services and items.

  ➔ To learn more about coverage decisions, see Chapter 9.

- **Appeals about your services and items**

  An *appeal* is a formal way of asking us to review a decision we or your IDT made about your coverage and asking us to change it if you think we or your IDT made a mistake.

  ➔ To learn more about making an appeal, see Chapter 9.

- **Grievances about your services and items**

  You can file a grievance (also called "making a complaint") about us or any provider (including a non-network or network provider). A network provider is a provider who works with Aetna Better Health FIDA Plan. You can also file a grievance about the quality of the care you got to us or to the Quality Improvement Organization (see Section G below).

➔ Note: If you disagree with a coverage decision that Aetna Better Health FIDA Plan or your IDT made about your services or items, you can file an appeal (see the section above).

You can also send a grievance about Aetna Better Health FIDA Plan right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

➔ To learn more about filing a grievance, see Chapter 9.

- **Coverage decisions about your drugs**

  A coverage decision is a decision about whether you can get certain covered drugs or how much you can have of a certain covered drug. This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs as covered by Aetna Better Health FIDA Plan. See Chapter 5 and the List of Covered Drugs for more information on your drug benefits and how to get covered drugs.

  ➔ For more on coverage decisions about your prescription drugs, see Chapter 9.

- **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, see Chapter 9.

- **Grievances about your drugs**

  You can file a grievance (also called "making a complaint") about us or any pharmacy. This includes a grievance about your prescription drugs.

  ➔ Note: If you disagree with a coverage decision about your prescription drugs, you can file an appeal (see the section above).

  You can also send a grievance about Aetna Better Health FIDA Plan right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

  ➔ For more on filing a grievance about your prescription drugs, see Chapter 9.

- **Payment for health care or drugs you already paid for**

  To learn how to ask us to pay you back, see Chapter 7.

B. How to contact your Care Manager

As an Aetna Better Health FIDA Plan participant, you will be assigned a Care Manager based on where you live and your language needs. This is a person who works with you and your care providers to make sure you get the care and services you need. You will receive a call from your Care Manager who will welcome you to our plan. Your Care Manager will identify any urgent issues that may require immediate assistance during your call. Your Care Manager will give you his or her phone number and email address so you can contact him or her. You can also contact your Care Manager by calling our Participant Services at **1-855-494-9945** (TTY: **711**). It is important that you have a good relationship with your Care Manager. If you want to change your Care Manager, please call Participant Services.

CALL	**1-855-494-9945** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week
WRITE	Aetna Better Health FIDA Plan 55 West 125th Street, Suite 1300 New York, NY 10027
WEBSITE	**www.aetnabetterhealth.com/newyork**

Contact your Care Manager about:

- **Questions about your care and covered services, items, and drugs**
- **Assistance in making and getting to appointments**
- **Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)**
- **Requests for services, items, and drugs**
- **Requests for a Comprehensive Reassessment or changes to a Person-Centered Service Plan**

C. How to contact the Nurse Advice Call Line

Aetna Better Health FIDA Plan has a Nurse Advice Line available to help answer your medical questions, give advice on treatment options and confirm enrollment. The Nurse Advice Line does not take the place of your primary care provider but is available as another resource for you. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. You can contact the Nurse Advice Line at **1-855-494-9945** (TTY: **711**).

CALL	**1-855-494-9945** This call is free. The Nurse Advice Call Line is available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. The Nurse Advice Call Line is available 24 hours a day, 7 days a week.

Contact the Nurse Advice Call Line about:

- **Immediate questions about your health**

D. How to contact the Behavioral Health Crisis Line

Aetna Better Health FIDA Plan offers a Behavioral Health Crisis Line. If you need immediate behavioral health care and do not know who to call, you can call our Behavioral Health Crisis Line. It is staffed by medical professionals who can help get you the care you need when you need immediate help for a mental health or alcohol or drug addiction crisis. This number is available 24 hours a day, 7 days a week.

Some symptoms of a behavioral health crisis are:

- Hopelessness, feeling like there is no way out
- Anxiety, sleeplessness or mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

CALL	**1-855-494-9945** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week.

Contact the Behavioral Health Crisis Line about:

- **Questions about behavioral health services**
- **Any issues you might be having**

E. How to contact the Enrollment Broker

New York Medicaid Choice is New York State's Enrollment Broker for the FIDA program. New York Medicaid Choice provides free counseling about your FIDA Plan options and can help you enroll or disenroll in a FIDA Plan.

New York Medicaid Choice is not connected with any insurance company, managed care plan, or FIDA Plan.

CALL	1-855-600-FIDA This call is free. The Enrollment Broker is available Monday through Friday from 8:30 am to 8:00 pm, and Saturday from 10:00 am to 6:00 pm.
TTY	1-888-329-1541 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	New York Medicaid Choice P.O. Box 5081 New York, NY 10274
WEBSITE	http://www.nymedicaidchoice.com

Contact New York Medicaid Choice about:

- **Questions about your FIDA Plan options**

  New York Medicaid Choice counselors can:

  » help you understand your rights,

  » help you understand your FIDA Plan choices, and

  » answer your questions about changing to a new FIDA Plan.

F. How to contact the State Health Insurance Assistance Program (SHIP)

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

HIICAP is not connected with any insurance company, managed care plan, or FIDA Plan.

CALL	1-800-701-0501 This call is free.
WEBSITE	http://www.aging.ny.gov/healthbenefits

You may also contact your local HIICAP office directly:

LOCAL OFFICE	CALL	WRITE
Nassau County	516-485-3754	Office of Children and Family Services 400 Oak Street Garden City, NY 11530
New York City	212-602-4180	Department for the Aging Two Lafayette Street, 16th Floor New York, NY 10007-1392
Suffolk County	631-979-9490	RSVP Suffolk 811 West Jericho Turnpike, Suite 103W Smithtown, NY 11787
Westchester County	914-813-6651	Department of Senior Programs & Services 9 South First Avenue, 10th Floor Mt. Vernon, NY 10550

Contact HIICAP about:

- **Questions about your Medicare health insurance**

  HIICAP counselors can:

  » help you understand your rights,

  » help you understand your Medicare plan choices, and

  » answer your questions about changing to a new Medicare plan.

G. How to contact the 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 This call is free. Livanta is available Monday through Friday from 9:00 am to 5:00 pm, and Saturday through Sunday from 11:00 am to 3:00 pm.
WRITE	BFCC-QIO Program 9090 Junction Dr., Suite 10 Annapolis Junction, MD 20701
EMAIL	BFCCQIOArea1@livanta.com
WEBSITE	http://bfccqioarea1.com

Contact Livanta about:

- **Questions about your health care**

  You can make a complaint about the care you got if:

  » You have a problem with the quality of care,

  » You think your hospital stay is ending too soon, ***or***

  » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

H. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, 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 hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	http://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, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Forms, Help & Resources" and then clicking on "Phone numbers & websites." The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

I. How to contact Medicaid

Medicaid 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 Medicaid Helpline.

CALL	1-800-541-2831 This call is free. The Medicaid Helpline is available Monday through Friday from 8:00 am to 8:00 pm and Saturday from 9:00 am to 1:00 pm.
TTY	1-877-898-5849 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

J. How to contact the Independent Consumer Advocacy Network

The Independent Consumer Advocacy Network (ICAN) helps people enrolled in a FIDA Plan with access to covered services and items, questions about billing, or other questions and problems. ICAN can help you file a grievance or an appeal with our plan.

CALL	1-844-614-8800 This call is free. ICAN is available Monday through Friday from 8:00 am to 8:00 pm.
TTY	Call 711, then follow the prompts to dial 844-614-8800
EMAIL	ican@cssny.org
WEBSITE	http://www.icannys.org

K. How to contact the New York State Long-Term Care Ombudsman

The Long-Term Care Ombudsman Program helps people learn about nursing facilities and other long-term care settings. It also helps solve problems between these settings and residents or their families.

CALL	1-800-342-9871 This call is free.
WEBSITE	http://www.ltcombudsman.ny.gov

You may also contact your local long-term care ombudsman directly. The contact information for the ombudsman in your county can be found in the directory at the following website: http://www.ltcombudsman.ny.gov/Whois/directory.cfm.

L. Other resources

The agencies in this section are part of a comprehensive service system designed to assist area residents in maintaining maximum independence.

Nassau County Department of Senior Citizen Affairs

CALL	(516) 227-8900
TTY	(516) 227-8926
FAX	(516) 227-8972
WRITE	Nassau County Department of Senior Citizens Affairs 60 Charles Lindbergh Boulevard Suite #260 Uniondale, NY 11553-3691
EMAIL	seniors@hhsnassaucountyny.us
WEBSITE	http://www.nassaucountyny.gov/agencies/Seniors/index.html

New York City Department for the Aging

CALL	Within the five boroughs of NYC – 311 Outside of the five boroughs of NYC – (212) 639-9675
TTY	(212) 504-4115
FAX	(212) 442-1095
WRITE	New York City Department for the Aging 2 Lafayette Street, 7th Floor New York, NY 10007-1392
WEBSITE	http://www.nyc.gov/html/dfta/html/home/home.shtml

Suffolk County Office for the Aging

CALL	(631) 853-8200
FAX	(631) 853-8225
WRITE	Suffolk County Office for the Aging H. Lee Dennison Building, 3rd Floor 100 Veterans Memorial Highway P.O. Box 6100 Hauppauge, NY 11788-0099
WEBSITE	http://suffolkcountyny.gov/aging/Home.aspx

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

Table of Contents

A. About "services and items," "covered services and items," "providers," and "network providers"

Services and items are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services and items** are any of these services and items that Aetna Better Health FIDA Plan pays for. Covered health care and long-term services and supports include those listed in the Covered Items and Services Chart in Chapter 4 and any other services that Aetna Better Health FIDA Plan, your IDT, or an authorized provider decides are necessary for your care.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you pay nothing for covered services or items.

B. General rules for getting your health care, behavioral health, and long-term services and supports covered by Aetna Better Health FIDA Plan

Aetna Better Health FIDA Plan covers all services covered by Medicare and Medicaid plus some additional services and items available through the FIDA Program. These include behavioral health, long term supports and services, and prescription drugs.

Aetna Better Health FIDA Plan will generally pay for the services and items you need if you follow the plan rules for how to get them. To be covered:

- The care you get must be **a service or item covered by the plan**. This means that it must be included in the plan's Covered Items and Services Chart. (The chart is in Chapter 4 of this handbook). Other services and items that are not listed in the chart may also be covered if your Interdisciplinary Team (IDT) determines they are necessary for you.
- The care must be **medically necessary**. *Medically necessary* means those services and items necessary to prevent, diagnose, correct, or cure conditions you have that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. 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.
- You will have and are expected to cooperate with an **Interdisciplinary Team (IDT)**. Your IDT will assess your needs, work with you and/or your designee to plan your care and services, and make sure that you get the necessary care and services. You can find more information about the IDT in Section C.

If you have questions, please call Aetna Better Health FIDA Plan at 1-855-494-9945 (TTY: 711), 24 hours a day, 7 days a week. The call is free. For more information, visit www.aetnabetterhealth.com/newyork.

- » In most cases, you must get approval from Aetna Better Health FIDA Plan, your IDT, or an authorized provider before you can access covered services and items. This is called *prior authorization*. To learn more about prior authorization, see page 34.
- » You do not need prior authorization for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having prior authorization. To learn more about this, see page 34.

- You will have a **Care Manager** who will serve as your primary point of contact with your IDT. You can find more information about the Care Manager in Section D.
- You must choose a network provider to serve as your **Primary Care Provider (PCP)**. **You may** also choose to have your PCP be a member of your IDT. To learn more about choosing or changing a PCP, see page 32.
- **You must get your services and items from network providers.** Usually, Aetna Better Health FIDA Plan will not cover services or items from a provider who has not joined Aetna Better Health FIDA Plan's network. Here are some cases when this rule does not apply:
  - » The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 37.
  - » If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. To learn about getting approval to see an out-of-network provider, see page 33.
  - » The plan covers services and items from out-of-network providers and pharmacies when a provider or pharmacy is not available within a reasonable distance from your home.
  - » The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - » When you first join the plan, you can continue seeing the providers you see now during the "transition period." In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later. However, your out-of-network provider must agree to provide ongoing treatment and accept payment at our rates. After the transition period, we will no longer cover your care if you continue to see out-of-network providers.
  - » If you are a resident of a nursing facility, you can continue to live in that nursing facility for the duration of the FIDA Program, even if the nursing facility does not participate in Aetna Better Health FIDA Plan's network.
  - » If you are getting services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years.

C. Your Interdisciplinary Team (IDT)

Every Participant has an Interdisciplinary Team (IDT). Your IDT will include the following individuals:

- You and your designee(s) and
- Your Care Manager.

You may also choose to have any of the following people participate in any or all of your IDT meetings:

- Your Primary Care Provider (PCP), including a physician, nurse practitioner, physician assistant, or specialist who has agreed to serve as your PCP, or a designee from your PCP's practice who has clinical experience (such as a registered nurse, nurse practitioner, or physician assistant) and knowledge of your needs;
- Your Behavioral Health (BH) Professional, if you have one, or a designee from your BH Professional's practice who has clinical experience and knowledge of your needs;
- Your home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of your needs, if you are getting home care;
- A clinical representative from your nursing facility, if getting nursing facility care; and
- Additional individuals including:
  - » Other providers either as asked for by you or your designee, or as recommended by the IDT members as necessary for adequate care planning and approved by you or your designee; or
  - » The registered nurse (RN) who completed your assessment.

The FIDA Plan Care Manager is the IDT lead. Your IDT conducts your service planning and develops your Person-Centered Service Plan (PCSP). Your IDT authorizes some or all of the services in your PCSP, depending on whether your PCP participated in the process for developing your PCSP. These decisions cannot be changed by Aetna Better Health FIDA Plan.

D. Your Care Manager

What is a Care Manager?

The FIDA Plan Care Manager coordinates your Interdisciplinary Team (IDT). The Care Manager will ensure the integration of your medical, behavioral health, substance use, community-based or facility-based long-term services and supports (LTSS), and social needs. The Care Manager will coordinate these services as specified in your Person-Centered Service Plan.

Who gets a Care Manager?

All Participants have a Care Manager. Your Care Manager assignment or selection first occurs when you are enrolled in Aetna Better Health FIDA Plan.

How can I contact my Care Manager?

When a Care Manager is assigned or selected, Aetna Better Health FIDA Plan will provide you with contact information for your Care Manager. Participant Services can also provide this information to you at any time during your participation in Aetna Better Health FIDA Plan.

How can I change my Care Manager?

You may change your Care Manager at any time, but you will have to choose from a list of Aetna Better Health FIDA Plan Care Managers. If you have an existing Care Manager (from Managed Long-Term Care, or MLTC, for example), you may ask to have the same person be your FIDA Plan Care Manager. If the Care Manager is also available in the FIDA Plan and the Care Manager's caseload permits, Aetna Better Health FIDA Plan must honor your request. To change Care Managers, contact Participant Services at **1-855-494-9945**, (TTY: **711**), 24 hours a day, 7 days a week.

E. Getting care from Primary Care Providers, specialists, other network providers, and out-of-network providers

Getting care from a Primary Care Provider (PCP)

You must choose a Primary Care Provider (PCP) to provide and manage your care. Aetna Better Health FIDA Plan will offer you the choice of at least three Primary Care Providers to select from. If you do not choose a PCP, one will be assigned to you. You can change your PCP at any time by contacting Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

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

Your Primary Care Provider (PCP) is your main doctor and will be responsible for providing many of your preventive and primary care services. Your PCP will be a part of your Interdisciplinary Team (IDT), if you so choose. If your PCP is part of your IDT, your PCP will participate in developing your Person-Centered Service Plan, making coverage determinations as a member of your IDT, and recommending or requesting many of the services and items your IDT or Aetna Better Health FIDA Plan will authorize.

How will I get a PCP?

We will give you a choice of at least three PCPs. If you don't choose a PCP, we will assign one to you. In assigning a PCP to you, we will consider how far the PCP is from your home, any special health care needs you have, and any special language needs you have.

If you already have a PCP when you join the plan, you will be able to continue seeing that PCP during the transition period (see page 7 for more information). After the transition period, you can continue to see that PCP if he/she is in our network.

Can a clinic be my PCP?

No. Your PCP may not be a clinic and must be a specific type of provider that meets certain requirements. If the PCP works at a clinic and otherwise meets all criteria, that provider can be designated as a PCP.

Changing your PCP

You may change your PCP for any reason, at any time. Simply call Aetna Better Health FIDA Plan and ask for a new PCP. The plan will process your request and tell you the effective date of the change, which will be within five business days of your request.

If your current PCP leaves our network or otherwise becomes unavailable, Aetna Better Health FIDA Plan will provide you with an opportunity to select a new PCP.

How to get 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. Here are a few examples:

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

Aetna Better Health FIDA Plan or your IDT will authorize specialist visits that are appropriate for your conditions. Access to specialists must be approved by Aetna Better Health FIDA Plan or your IDT through a standing authorization or through pre-approval of a fixed number of visits to the specialist. This information will be included in your Person-Centered Service Plan (PCSP).

What if a network provider leaves our plan?

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 15 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Contact Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

How to get care from out-of-network providers

If you need care that our plan covers and our network providers cannot give it to you, you can get permission from Aetna Better Health FIDA Plan or your IDT to get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. To get approval to see an out-of-network provider, you or the provider you plan to see can call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

If you have questions, please call Aetna Better Health FIDA Plan at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/newyork**.

Remember, when you first join the plan, you can continue seeing the providers you see now during the "transition period." In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later. During the transition period, our Care Manager will contact you to help you find and switch to providers that are in our network. After the transition period, we will no longer pay for your care if you continue to see out-of-network providers, unless Aetna Better Health FIDA Plan or your IDT has authorized you to continue to see the out-of-network provider.

→ **Please note:** If you need to go to an out-of-network provider, please work with Aetna Better Health FIDA Plan or your IDT to get approval to see an out-of-network provider and to find one that meets applicable Medicare or Medicaid requirements. If you go to an out-of-network provider without first getting Plan or IDT approval, you may have to pay the full cost of the services you get.

F. Getting approval for services and items that require prior authorization

Your Interdisciplinary Team (IDT) is responsible for authorizing all services and items that can be anticipated during the development of your Person-Centered Service Plan (PCSP). However, your IDT may not be able to authorize all of your services if your PCP does not participate on the IDT. For example, if there is no PCP or other physician participating in a given IDT meeting, the IDT cannot authorize new prescription medications. In those cases, your IDT will add the list of requested prescription medications to the PCSP. Aetna Better Health FIDA Plan will then review and approve the prescription medications if they are medically necessary.

In addition, Aetna Better Health FIDA Plan and certain authorized providers are responsible for authorizing most of the health care services and items you might need in between IDT service planning meetings and PCSP updates. These are services and items that could not have been planned or predicted and therefore were not included in your PCSP.

Services you can get without first getting authorization

In most cases, you will need approval from Aetna Better Health FIDA Plan, your IDT, or certain authorized providers before seeing other providers. This approval is called "prior authorization." You can get services like the ones listed below without first getting approval:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to network providers because you are outside the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Participant Services before you leave the service area. We can help you get dialysis while you are away.)

- Immunizations, including flu shots, hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Primary Care Provider (PCP) visits.
- Palliative care.
- Other preventive services.
- Services from public health agency facilities for tuberculosis screening, diagnosis and treatment, including Directly Observed Therapy (TB/DOT).
- Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
- Dental services through Article 28 clinics operated by Academic Dental Centers.
- Cardiac rehabilitation for the first course of treatment (a Physician or RN authorization is required for courses of treatment following the first course).
- Supplemental education, wellness, and health management services.
- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without approval from Aetna Better Health FIDA Plan or your IDT.

G. How to get long-term services and supports (LTSS)

Community-based LTSS are a range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health. These services are provided in the person's home or a community-based setting such as assisted-living facilities. Facility-based LTSS are services provided in a nursing facility or other long-term residential care setting.

As a Participant in Aetna Better Health FIDA Plan, you will get a comprehensive assessment of your needs, including your need for community-based or facility-based LTSS. All of your needs, as identified in your assessment, will be addressed in your Person-Centered Service Plan (PCSP). Your PCSP will outline which LTSS you will get, from whom, and how often.

If you have a pre-existing service plan prior to your enrollment into Aetna Better Health FIDA Plan, you will continue to get any community-based or facility-based LTSS included in the pre-existing plan. Your pre-existing service plan will be honored for 90 days or until your PCSP is finalized and implemented, whichever is later.

→ If you have questions about LTSS, contact Participant Services or your Care Manager.

H. How to get behavioral health services

Behavioral health services are a variety of services that can support mental health and substance abuse needs you may have. This support can include emotional, social, educational, vocational, peer support and recovery services, in addition to more traditional psychiatric or medical services.

As a Participant in Aetna Better Health FIDA Plan, you will get a comprehensive assessment of your needs, including your need for behavioral health services. All of your needs, as identified in your assessment, will be addressed in your Person-Centered Service Plan (PCSP). Your PCSP will outline which behavioral health services you will get, from whom, and how often.

If you are getting services from a behavioral health provider at the time of your enrollment in Aetna Better Health FIDA Plan, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in Aetna Better Health FIDA Plan's network.

→ If you have questions about behavioral health services, contact Participant Services or your Care Manager.

I. How to get self-directed care

You have the opportunity to direct your own services through the Consumer Directed Personal Assistance Services (CDPAS) program.

If you are chronically ill or physically disabled and have a medical need for help with activities of daily living (ADLs) or skilled nursing services, you can get services through the CDPAS program. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. You have flexibility and freedom in choosing your caregivers.

You must be able and willing to make informed choices about the management of the services you get, or have a legal guardian or designated relative or other adult able and willing to help make informed choices.

You or your designee must also be responsible for recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services, and keep payroll records.

Your Care Manager and Interdisciplinary Team (IDT) will review the CDPAS option with you during your IDT meetings. You can select this option at any time by contacting your Care Manager.

J. How to get transportation services

Aetna Better Health FIDA Plan will provide you with emergency and non-emergency transportation. Your Interdisciplinary Team (IDT) will discuss your transportation needs and will plan for how to meet them. Call your Care Manager any time you need transportation to a provider in order to get covered services and items.

Transportation coverage includes a transportation attendant to accompany you somewhere, if necessary.

Transportation is also available to non-medical events or services such as religious services, community activities, or supermarkets.

K. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

Getting care when you have a medical emergency

What is a medical emergency?

A *medical or behavioral health emergency* is a condition with severe symptoms, 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:

- placing your health (or, with respect to a pregnant woman, your health or that of your unborn child) in serious jeopardy, or in the case of a behavioral condition, placing your health or the health of others in serious jeopardy; ***or***
- serious harm to bodily functions; ***or***
- serious dysfunction of any bodily organ or part; ***or***
- serious disfigurement; ***or***
- in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - » There is not enough time to safely transfer you to another hospital before delivery.
  - » The transfer may pose a threat to your health or safety or to that of your unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval from Aetna Better Health FIDA Plan or your IDT.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, Aetna Better Health FIDA Plan covers that. To learn more, see the Covered Items and Services Chart in Chapter 4.

If you have an emergency, your Care Manager will talk with the doctors who give you emergency care. Those doctors will tell your Care Manager when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by Aetna Better Health FIDA Plan. If you get your emergency care from out-of-network providers, your Care Manager will try to get network providers to take over your care as soon as possible.

What if it wasn't a medical emergency after all?

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

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- you go to a network provider, ***or***
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

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

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

You are always able to call your doctor (PCP) regardless of their office hours. If the office is closed, the after-hours staff will relay your information to your doctor or the doctor on call and they will follow up with you to tell you what to do next. If you need help with how to get care, call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. You may also speak with your care manager or nurse 24 hours a day, 7 days a week for help locating the nearest urgent care facility. Remember to take your Aetna Better Health of New York FIDA identification card with you.

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➔ Our plan does not cover urgently needed care or any other care that you get outside the United States.

Getting care during a disaster

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

Please visit our website for information on how to obtain needed care during a declared disaster: **www.aetnabetterhealth.com/newyork**.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

L. What if you are billed directly for the full cost of services and items covered by Aetna Better Health FIDA Plan?

Providers should only bill Aetna Better Health FIDA Plan for the cost of your covered services and items. If a provider sends you a bill instead of sending it to Aetna Better Health FIDA Plan, you can send it to us to pay. **You should not pay the bill yourself.** But if you do, Aetna Better Health FIDA Plan may pay you back.

→ If you have paid for your covered services or items, or if you have gotten a bill for covered services or items, **see Chapter 7 to learn what to do**.

What should you do if services or items are not covered by our plan?

Aetna Better Health FIDA Plan covers all services and items:

- that are medically necessary, ***and***
- that are listed in the plan's Covered Items and Services Chart or that your Interdisciplinary Team (IDT) determines are necessary for you (see Chapter 4), ***and***
- that you get by following plan rules.

→ If you get services or items that aren't covered by Aetna Better Health FIDA Plan, **you must pay the full cost yourself**.

If you want to know if we will pay for any services or items, 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 or items, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical service or item. It also tells you how to appeal a coverage decision. You may also call Participant Services to learn more about your appeal rights.

If you disagree with a decision made by the plan, you may contact the Independent Consumer Advocacy Network (ICAN) to help you appeal the decision. ICAN provides free information and assistance. You can call ICAN at 1-844-614-8800, Monday through Friday from 8:00 am to 8:00 pm. (TTY users call **711**, then follow the prompts to dial 844-614-8800.)

M. How are your health care services covered when you are in a clinical research study?

What is 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. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from Aetna Better Health FIDA Plan, your IDT, or your Primary Care Provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study.

Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Care Manager should contact Participant Services.

When you are in a clinical research study, who pays for what?

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay 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 are covered for most items and services 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 are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study**.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (https://www.medicare.gov/Pubs/pdf/02226.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.

N. How are your health care services covered when you are in a religious non-medical health care institution?

What is 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 will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

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

To get care from a religious non-medical health care institution, you must sign a legal document that says you are 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.
- Aetna Better Health FIDA 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, the following applies:
  - » 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 Aetna Better Health FIDA Plan or your IDT before you are admitted to the facility or your stay will not be covered.
- Our plan will cover unlimited inpatient hospital days in a network hospital when medically necessary and with prior authorization.

O. Rules for owning durable medical equipment

Will you own your durable medical equipment?

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. Other types of durable medical equipment will be rented for you by Aetna Better Health FIDA Plan. Examples of items that must be rented are wheelchairs, hospital beds, and continuous positive airway pressure (CPAP) devices.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months.

What happens if you lose your Medicaid coverage?

If you lose your Medicaid coverage and leave the FIDA Program, you will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan ***and***
- you get your Medicare benefits in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined Aetna Better Health FIDA Plan, those Medicare payments do not count toward the 13 payments you would have to make after your Medicaid ends. You will have to make 13 new payments in a row under Original Medicare to own the item.

➔ There are no exceptions to this case when you return to Original Medicare. If you join a Medicare health plan (such as a Medicare Advantage plan) instead of Original Medicare, you should check with the plan about its coverage of durable medical equipment.

What happens if you change your FIDA Plan or leave FIDA and join an MLTC Plan?

If you join another FIDA Plan or a Managed Long-Term Care (MLTC) Plan, your Care Manager at your new plan will work with you to ensure that you continue to have access to the durable medical equipment you are getting through Aetna Better Health FIDA Plan.

Chapter 4: Covered Items and Services

Table of Contents

A. Understanding your covered items and services

This chapter tells you what items and services Aetna Better Health FIDA Plan pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

Because you are a FIDA Participant, you pay nothing for your covered items and services as long as you follow Aetna Better Health FIDA Plan's rules. See Chapter 3 for details about the plan's rules.

If you need help understanding what services are covered, call your Care Manager and/or Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

B. Aetna Better Health FIDA Plan does not allow providers to charge you for covered items or services

We do not allow Aetna Better Health FIDA Plan providers to bill you for covered items or 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 items and services. If you do, see Chapter 7 or call Participant Services.**

C. About the Covered Items and Services Chart

This Covered Items and Services Chart tells you which items and services Aetna Better Health FIDA Plan pays for. It lists items and services in alphabetical order and explains the covered items and services.

We will pay for the items and services listed in the Covered Items and Services Chart only when the following rules are met. You do not pay anything for the items and services listed in the Covered Items and Services Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medicaid covered items and services must be provided according to the rules set by Medicare and Medicaid.
- The items and services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need items and services to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger your life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap.
- You get your care from a network provider. A network provider is a provider who works with Aetna Better Health FIDA Plan. In most cases, Aetna Better Health FIDA Plan will not pay for care you get from an out-of-network provider, unless it is approved by your Interdisciplinary Team (IDT) or Aetna Better Health FIDA Plan. Chapter 3 has more information about using network and out-of-network providers.
- You have an Interdisciplinary Team (IDT) that will arrange and manage your care. For more information on your IDT, see Chapter 3.
- Most of the items and services listed in the Covered Items and Services Chart are covered only if your IDT, Aetna Better Health FIDA Plan, or an authorized provider approves them. This is called *prior authorization*. The Covered Items and Services Chart tells you when an item or service does not require prior authorization.

Most preventive services are covered by Aetna Better Health FIDA Plan. You will see this apple next to preventive services in the benefits chart.

D. The Covered Items and Services Chart

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Abdominal aortic aneurysm screening 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 Aetna Better Health FIDA Plan will pay for 9 treatments per year. This service does not require prior authorization.	$0
Adult day health care Aetna Better Health FIDA Plan will pay for adult day health care for Participants who are functionally impaired, not homebound, and who require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services. Adult day health care includes the following services: ▪ Medical ▪ Nursing ▪ Food and nutrition ▪ Social services ▪ Rehabilitation therapy ▪ Leisure time activities, which are a planned program of diverse meaningful activities ▪ Dental ▪ Pharmaceutical ▪ Other ancillary services	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
AIDS adult day health care Aetna Better Health FIDA Plan will pay for AIDS adult day health care programs (ADHCP) for Participants with HIV. ADHCP includes the following services: ▪ Individual and group counseling/education provided in a structured program setting ▪ Nursing care (including triage/assessment of new symptoms) ▪ Medication adherence support ▪ Nutritional services (including breakfast and/or lunch) ▪ Rehabilitative services ▪ Substance abuse services ▪ Mental health services ▪ HIV risk reduction services	$0
Alcohol misuse screening and counseling The plan will 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 provider practitioner in a primary care setting. This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground 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 life or health. Ambulance services for other cases must be approved by your IDT or Aetna Better Health FIDA Plan. In cases that are *not* emergencies, your IDT or Aetna Better Health FIDA Plan may authorize use of an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0
Ambulatory surgical center services Aetna Better Health FIDA Plan will pay for covered surgical procedures provided at ambulatory surgical centers.	$0
Annual wellness visit / routine physical exam If you have been in Medicare Part B for more than 12 months, you can get an annual wellness checkup. This is to develop or update a prevention plan based on your current health and risk factors. Aetna Better Health FIDA Plan will pay for this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first. This service does not require prior authorization.	$0
Assertive community treatment (ACT) Aetna Better Health FIDA Plan will pay for ACT services. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Assisted living program Aetna Better Health FIDA Plan will pay for Assisted Living Program services provided in an adult home or enriched housing setting. Services include: ▪ Personal care ▪ Housekeeping ▪ Supervision ▪ Home health aides ▪ Personal emergency response services ▪ Nursing ▪ Physical, occupational, and/or speech therapy ▪ Medical supplies and equipment ▪ Adult day health care ▪ A range of home health services ▪ Case management services of a registered professional nurse	$0
Assistive technology Aetna Better Health FIDA Plan will pay for physical adaptations to the private residence of the Participant or the Participant's family. The adaptations must be necessary to ensure the health, welfare, and safety of the Participant or enable the Participant to function with greater independence in the home. Covered adaptations include: ▪ Installation of ramps and grab bars ▪ Widening of doorways ▪ Modifications of bathrooms ▪ Installation of specialized electric and plumbing systems	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Bone mass measurement Aetna Better Health FIDA Plan will pay for certain procedures for Participants 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. Aetna Better Health FIDA Plan will pay for the services once every 24 months, or more often if they are medically necessary. Aetna Better Health FIDA Plan will also pay for a doctor to look at and comment on the results. This service does not require prior authorization.	$0
Breast cancer screening (mammograms) Aetna Better Health FIDA Plan will 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 older ▪ Clinical breast exams once every 24 months This service does not require prior authorization.	$0
Cardiac (heart) rehabilitation services Aetna Better Health FIDA Plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Participants must meet certain conditions with a provider's order. Aetna Better Health FIDA Plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) Aetna Better Health FIDA Plan pays for one visit a year with your Primary Care Provider (PCP) to help lower your risk for heart disease. During this visit, your doctor may: ▪ discuss aspirin use, ▪ check your blood pressure, or ▪ give you tips to make sure you are eating well. This service does not require prior authorization.	$0
Cardiovascular (heart) disease screening and testing Aetna Better Health FIDA Plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. This service does not require prior authorization.	$0
Care management (service coordination) Care management is an individually designed intervention that helps the Participant get access to needed services. These care management interventions are designed to ensure the Participant's health and welfare and increase the Participant's independence and quality of life. This service does not require prior authorization.	$0
Cervical and vaginal cancer screening Aetna Better Health FIDA Plan will pay for the following services: ▪ For all women: Pap tests and pelvic exams once every 24 months ▪ For women who are at high risk of cervical cancer: one Pap test and pelvic exam every 12 months ▪ For women who have had an abnormal Pap test and are of childbearing age: one Pap test and pelvic exam every 12 months This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Chemotherapy Aetna Better Health FIDA Plan will pay for chemotherapy for cancer patients. Chemotherapy is covered when it is provided in an inpatient or outpatient unit of a hospital, a provider's office, or a freestanding clinic.	$0
Chiropractic services Aetna Better Health FIDA Plan will pay for the following services: ▪ Adjustments of the spine to correct alignment	$0
Colorectal cancer screening Aetna Better Health FIDA Plan will pay for the following: ▪ Barium enema » Covered once every 48 months if you're 50 or over and once every 24 months if you're at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or colonoscopy. ▪ Colonoscopy » Covered once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy. ▪ DNA based colorectal screening » Covered once every 3 years if you're 50 or over. ▪ Fecal occult blood test » Covered once every 12 months if you're 50 or older. ▪ Flexible sigmoidoscopy » Covered once every 48 months for most people 50 or older. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy. ▪ Guaiac-based fecal occult blood test or fecal immunochemical test » Covered once every 12 months if you're 50 or over. This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Community integration counseling Aetna Better Health FIDA Plan will pay for community integration counseling. This is a counseling service provided to Participants who are coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the Participant's home. Community integration counseling services are usually provided in one-to-one counseling sessions. However, there are times when it is appropriate to provide this service to the Participant in a family counseling or group counseling setting.	$0
Community transitional services Aetna Better Health FIDA Plan will pay for Community Transitional Services (CTS). These services help a Participant transition from living in a nursing facility to living in the community. CTS includes: ▪ The cost of moving furniture and other belongings ▪ Buying certain essential items such as linen and dishes ▪ Security deposits, including broker's fees required to obtain a lease on an apartment or home ▪ Buying essential furnishings ▪ Set-up fees or deposits for utility or service access (for example, telephone, electricity, or heating) ▪ Health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy CTS cannot be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.	$0
Comprehensive Psychiatric Emergency Programs (CPEPs) Aetna Better Health FIDA Plan will pay for Office of Mental Health licensed programs that directly provide or help you get a full range of psychiatric emergency services. These services are provided 24 hours a day, seven days a week.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Consumer directed personal assistance services (CDPAS) Aetna Better Health FIDA Plan will pay for CDPAS, which provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Participants who choose CDPAS have flexibility and freedom to choose their caregivers. The Participant or the person acting on the Participant's behalf (such as the parent of a disabled or chronically ill child) is responsible for recruiting, hiring, training, supervising, and, if necessary, terminating caregivers providing CDPAS services.	$0
Continuing day treatment Aetna Better Health FIDA Plan will pay for continuing day treatment. This service helps Participants maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Services include: ▪ Assessment and treatment planning ▪ Discharge planning ▪ Medication therapy ▪ Medication education ▪ Case management ▪ Health screening and referral ▪ Rehabilitative readiness development ▪ Psychiatric rehabilitative readiness determination and referral ▪ Symptom management	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Crisis intervention services If you are having a mental health crisis, Aetna Better Health FIDA Plan will pay for clinical intervention through your crisis intervention clinic. Crisis services do not need to be in your treatment plan in order to be covered. These services may be provided by phone or in person, with some exceptions. At a minimum, each clinic will have a clinician that can help you by phone 24 hours a day, seven days a week. At the clinic's option, it may provide face-to-face crisis services 24 hours a day, seven days a week.	$0
Defibrillator (implantable automatic) Aetna Better Health FIDA Plan will pay for defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.	$0
Dental services Aetna Better Health FIDA Plan will pay for the following dental services: ▪ Oral exams once every six months ▪ Cleaning once every six months ▪ Dental x-rays once every six months ▪ Diagnostic services ▪ Restorative services ▪ Endodontics, periodontics, and extractions ▪ Dental prosthetics and orthotic appliances required to alleviate a serious condition, including one that affects a Participant's employability ▪ Other oral surgery ▪ Dental emergencies ▪ Other necessary dental care Oral exams and cleanings require prior authorization by the plan or your IDT. X-rays and other dental services must be authorized by your dentist. However, dental services provided through Article 28 Clinics operated by Academic Dental Centers do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Depression screening Aetna Better Health FIDA Plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and recommendations for additional treatments. This service does not require prior authorization.	$0
Diabetes screening Aetna Better Health FIDA Plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: ▪ High blood pressure (hypertension) ▪ History of abnormal cholesterol and triglyceride levels (dyslipidemia) ▪ Obesity ▪ 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. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Diabetic self-management training, services, and supplies Aetna Better Health FIDA Plan will 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, Aetna Better Health FIDA Plan will pay for the following: » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) Aetna Better Health FIDA Plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. ▪ Aetna Better Health FIDA Plan will pay for training to help you manage your diabetes, in some cases.	$0
Diagnostic testing See "Outpatient diagnostic tests and therapeutic services and supplies" in this chart.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Durable medical equipment and related supplies Durable medical equipment includes items such as: ▪ Wheelchairs ▪ Crutches ▪ Hospital beds ▪ Nebulizers ▪ Oxygen equipment ▪ IV infusion pumps ▪ Walkers ▪ Speech generating devices We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Emergency care *Emergency care* means services that are: ▪ given by a provider trained to give emergency services, and ▪ needed to treat a medical or behavioral health emergency. A *medical or behavioral health emergency* is a condition with severe symptoms, 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: ▪ placing your health (or, with respect to a pregnant woman, your health or that of your unborn child) in serious jeopardy, or in the case of a behavioral condition, placing your health or the health of others in serious jeopardy; ▪ serious harm to bodily functions; or ▪ serious dysfunction of any bodily organ or part; or ▪ serious disfigurement; or ▪ in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: » There is not enough time to safely transfer you to another hospital before delivery. » The transfer may pose a threat to your health or safety or to that of your unborn child. Medical or behavioral health emergencies are only covered within the United States and its territories. This service does not require prior authorization.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the Aetna Better Health FIDA Plan approves your stay.

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Environmental modifications and adaptive devices Aetna Better Health FIDA Plan will pay for internal and external physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the Participant. Environmental modifications may include: ▪ Installation of ramps and grab bars ▪ Widening of doorways ▪ Modifications of bathroom facilities ▪ Installation of specialized electrical or plumbing systems to accommodate necessary medical equipment ▪ Any other modification necessary to ensure the participant's health, welfare or safety	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. Aetna Better Health FIDA Plan will pay for the following services: ▪ Family planning exam and medical treatment ▪ Family planning lab and diagnostic tests ▪ Family planning methods (birth control pills, patch, ring, IUD, injections, implants) ▪ Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap, emergency contraception, pregnancy tests) ▪ Counseling and diagnosis of infertility, and related services ▪ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions, as part of a family planning visit ▪ Treatment for sexually transmitted infections (STIs) ▪ Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) ▪ Abortion These services do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Health and wellness education programs Aetna Better Health FIDA Plan will pay for health and wellness education for Participants and their caregivers, which includes: ▪ Classes, support groups, and workshops ▪ Educational materials and resources ▪ Website, email, or mobile application communications These services are provided on topics including, but not limited to: heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources. This service does not require prior authorization.	$0
Hearing services Aetna Better Health FIDA Plan pays 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. Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include: ▪ Hearing aid selecting, fitting, and dispensing ▪ Hearing aid checks following dispensing ▪ Conformity evaluations and hearing aid repairs ▪ Audiology services, including examinations and testing ▪ Hearing aid evaluations and hearing aid prescriptions ▪ Hearing aid products, including hearing aids, earmolds, special fittings, and replacement parts when authorized by an audiologist	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
HIV screening Aetna Better Health FIDA Plan pays 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, Aetna Better Health FIDA Plan pays for up to three HIV screening tests during a pregnancy. This service does not require prior authorization.	$0
Home and community support services (HCSS) Aetna Better Health FIDA Plan will pay for HCSS for Participants who: ▪ require assistance with personal care services tasks, and ▪ whose health and welfare in the community is at risk because supervision of the Participant is required when no personal care task is being performed.	$0
Home delivered and congregate meals Aetna Better Health FIDA Plan will pay for congregate and home delivered meals. This is an individually designed service that provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when providing such meals will decrease the need for more costly supported in-home meal preparation. This benefit includes three meals a day for 52 weeks a year.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Home health services Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency. Aetna Better Health FIDA Plan will 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	$0
Home infusion Aetna Better Health FIDA Plan will pay for the administration of home infusion drugs and supplies.	$0
Home maintenance services Aetna Better Health FIDA Plan will pay for home maintenance services. Home maintenance services include household chores and services that are required to maintain an individual's home environment in a sanitary, safe, and viable manner. Chore services are provided on two levels: ▪ Light chores – Cleaning and/or washing of windows, walls, and ceilings; snow removal and/or yard work; tacking down loose rugs and/or securing tiles; and cleaning of tile work in bath and/or kitchen. Light chores are provided when needed. ▪ Heavy-duty chores – limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Heavy-duty chore services may include (but are not limited to) tasks such as scraping and/or cleaning of floor areas.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Home visits by medical personnel Aetna Better Health FIDA Plan will cover home visits by medical personnel to provide diagnosis, treatment, and wellness monitoring. The purpose of these home visits is to preserve the Participant's functional capacity to remain in the community. Wellness monitoring includes disease prevention, health education, and identifying health risks that can be reduced.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Hospice care You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: ▪ Drugs to treat symptoms and pain ▪ Short-term respite care ▪ Home care ***Hospice services and services covered by Medicare Part A or B are billed to Medicare.*** ▪ See Section F of this chapter for more information. ***For services covered by Aetna Better Health FIDA Plan but not covered by Medicare Part A or B:*** ▪ Aetna Better Health FIDA Plan will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. ***For drugs that may be covered by Aetna Better Health FIDA Plan's Medicare Part D benefit:*** ▪ Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5. **Note:** If you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Call your Care Manager at **1-855-494-9945** (TTY: **711**).	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Immunizations Aetna Better Health FIDA Plan will pay for the following services: ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B coverage rules Aetna Better Health FIDA Plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more. These services do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Independent living skills and training Independent Living Skills Training and Development (ILST) services are individually designed to improve or maintain the ability of the Participant to live as independently as possible in the community. ILST may be provided in the Participant's residence and in the community. Services may include assessment, training, and supervision of or assistance with: ▪ Self-care ▪ Medication management ▪ Task completion ▪ Communication skills ▪ Interpersonal skills ▪ Socialization ▪ Sensory/motor skills ▪ Mobility ▪ Community transportation skills ▪ Reduction/elimination of maladaptive behaviors ▪ Problem solving skills ▪ Money management ▪ Pre-vocational skills ▪ Ability to maintain a household	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Inpatient acute hospital care, including substance abuse and rehabilitative services Aetna Better Health FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ Semi-private room (or a private room if it is 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 services ▪ Blood, including storage and administration ▪ Physician services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, 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 whether 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 at a distant location outside the service area. If Aetna Better Health FIDA Plan provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.	$0 You must get approval from Aetna Better Health FIDA Plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Inpatient mental health care Aetna Better Health FIDA Plan will pay for mental health care services that require a hospital stay, including days in excess of the Medicare 190-day lifetime maximum.	$0
Inpatient services covered during a non-covered inpatient stay If your inpatient stay is not reasonable and needed, Aetna Better Health FIDA Plan will not pay for it. However, in some cases Aetna Better Health FIDA Plan will pay for services you get while you are in the hospital or a skilled nursing facility (SNF). Aetna Better Health FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ Provider services ▪ Diagnostic tests, like lab tests ▪ X-ray, radium, and isotope therapy, including technician materials and services ▪ Surgical dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: » replace all or part of an internal body organ (including contiguous tissue), or » replace all or part of the function of an inoperative or malfunctioning internal body organ. ▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the Participant's condition ▪ Physical therapy, speech therapy, and occupational therapy	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Intensive psychiatric rehabilitation treatment programs Aetna Better Health FIDA Plan will pay for time limited, active psychiatric rehabilitation designed to: ▪ Help a Participant form and achieve mutually agreed upon goals in living, learning, working, and social environments ▪ Intervene with psychiatric rehabilitative technologies to help a Participant overcome functional disabilities	$0
Kidney disease services and supplies, including End-Stage Renal Disease (ESRD) services Aetna Better Health FIDA Plan will pay for the following services: ▪ Kidney disease education services to teach kidney care and help Participants make good decisions about their care. You must have stage IV chronic kidney disease, and your IDT or Aetna Better Health FIDA Plan must authorize it. Aetna Better Health FIDA Plan will cover up to six sessions of kidney disease education services per lifetime. ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 ▪ Inpatient dialysis treatments if you are 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, please see "Medicare Part B prescription drugs" in this chart.** Kidney disease education services do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: ▪ Are aged 55-77, *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 30 years with no signs or symptoms of lung cancer *or* smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
Medical nutrition therapy This benefit is for Participants with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your provider. Aetna Better Health FIDA Plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes Aetna Better Health FIDA Plan, a Medicare Advantage plan, or Medicare.) 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 provider's request and approval by your IDT or Aetna Better Health FIDA Plan. A provider must prescribe these services and renew the request to the IDT or to Aetna Better Health FIDA Plan each year if your treatment is needed in the next calendar year. This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Medical social services Aetna Better Health FIDA Plan will pay for medical social services, which includes the assessment of social and environmental factors related to the Participant's illness and need for care. Services include: ▪ Home visits to the individual, family, or both ▪ Visits to prepare to transfer the Participant to the community ▪ Patient and family counseling, including personal, financial, and other forms of counseling services	$0
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Aetna Better Health FIDA Plan will pay for the following drugs: ▪ Drugs you don't usually give yourself and are injected or infused while you are getting provider, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by your IDT or Aetna Better Health FIDA Plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a provider certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ***This benefit is continued on the next page***	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Medicare Part B prescription drugs (continued) ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoeisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases → **Chapter 5 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. → **Chapter 6 provides additional information about your outpatient prescription drug coverage.**	$0
Medication therapy management (MTM) services Aetna Better Health FIDA Plan provides medication therapy management (MTM) services for Participants who take medications for different medical conditions. MTM programs help Participants and their providers make sure that Participants' medications are working to improve their health. → **Chapter 5 provides additional information about MTM programs.**	$0
Mobile mental health treatment Aetna Better Health FIDA Plan will pay for mobile mental health treatment, which includes individual therapy that is provided in the home. This service is available to Participants who have a medical condition or disability that limits their ability to come into an office for regular outpatient therapy sessions.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Moving assistance Aetna Better Health FIDA Plan will pay for moving assistance services. These are individually designed services intended to move a Participant's possessions and furnishings when the Participant must be moved from inadequate or unsafe housing to an environment which more adequately meets the Participant's health and welfare needs and reduces the risk of unwanted nursing facility placement. Moving assistance does not include items such as security deposits, including broker's fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (for example, telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control, or cleaning prior to occupancy.	$0
New York State Office of Mental Health Licensed Community Residences Aetna Better Health FIDA Plan will pay for behavioral health residential programs in these settings that provide rehabilitative and supportive services. These services focus on intensive, goal-oriented intervention, within a structured program setting, to address residents' needs regarding community integration. These services also include goal-oriented interventions which focus on improving or maintaining resident skills to enable living in community housing.	$0
Nurse advice call line Aetna Better Health FIDA Plan has a nurse advice line which is a toll-free phone service that Participants can call 24 hours a day, 7 days a week. Participants can call the nurse advice line for answers to general health related questions and for assistance in accessing services through Aetna Better Health FIDA Plan.	$0
Nursing facility care Aetna Better Health FIDA Plan will pay for nursing facilities for Participants who need 24-hour nursing care and supervision outside of a hospital.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Nutrition (includes nutritional counseling and educational services) Aetna Better Health FIDA Plan will pay for nutrition services provided by a qualified nutritionist. Services include: ▪ Assessment of nutritional needs and food patterns ▪ Planning for providing food and drink appropriate for the individual's physical and medical needs and environmental conditions These services do not require prior authorization.	$0
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, Aetna Better Health FIDA Plan will 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 Care Manager or Primary Care Provider (PCP) to find out more. This service does not require prior authorization.	$0
Other supportive services the IDT determines are necessary Aetna Better Health FIDA Plan will pay for additional supportive services or items determined by the Participant's IDT to be necessary for the Participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the Participant. One example is Aetna Better Health FIDA Plan paying for a blender to puree foods for a Participant who cannot chew.	$0
Outpatient blood services Blood, including storage and administration, beginning with the first pint you need.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies Aetna Better Health FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ CT scans, MRIs, EKGs and X-rays when a provider orders them as part of treatment for a medical problem ▪ 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 ▪ Medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition ▪ Blood, including storage and administration ▪ Other outpatient diagnostic tests	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Outpatient hospital services Aetna Better Health FIDA Plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Aetna Better Health FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ Labs and diagnostic tests billed by the hospital ▪ Mental health care, including care in a partial-hospitalization program, if a provider 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 ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Outpatient mental health care Aetna Better Health FIDA Plan will 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 nurse practitioner, ▪ a physician assistant, or ▪ any other Medicare-qualified mental health care professional as allowed under applicable state laws. Aetna Better Health FIDA Plan will pay for the following services: ▪ Individual therapy sessions ▪ Group therapy sessions ▪ Clinic services ▪ Day treatment ▪ Psychosocial rehab services Participants may directly access one assessment from a network provider in a twelve (12) month period without getting prior authorization.	$0
Outpatient rehabilitation services Aetna Better Health FIDA Plan will pay for Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST). You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. OT, PT, and ST services are limited to twenty (20) visits per therapy per calendar year except for individuals with intellectual disabilities, individuals with traumatic brain injury, and individuals under age 21	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Outpatient surgery Aetna Better Health FIDA Plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0
Over-the-counter Aetna Better Health FIDA Plan offers a $50 monthly over-the-counter (OTC) mail order benefit. Products must be purchased through the approved OTC catalog. There is no carry-over month-to-month. The benefit is for non-Medicaid OTC items. This service does not require prior authorization.	$0
Palliative care Aetna Better Health FIDA Plan will pay for interdisciplinary end-of-life care and consultation with the Participant and his/her family members. These services help to prevent or relieve pain and suffering and to enhance the Participant's quality of life. Services include: ▪ Family palliative care education ▪ Pain and symptom management ▪ Bereavement services ▪ Massage therapy ▪ Expressive therapies These services do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Partial hospitalization Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center. Partial hospitalization is more intense than the care you get in a provider or therapist's office and is an alternative to inpatient hospitalization. Aetna Better Health FIDA Plan will pay for partial hospitalization to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Services include: ▪ Assessment and treatment planning ▪ Health screening and referral ▪ Symptom management ▪ Medication therapy ▪ Medication education ▪ Verbal therapy ▪ Case management ▪ Psychiatric rehabilitative readiness determination ▪ Referral and crisis intervention	$0
Peer-delivered services Aetna Better Health FIDA Plan will pay for peer support services provided by a peer support provider. This is a person who assists individuals with their recovery from mental illness and substance abuse disorders.	$0
Peer mentoring Aetna Better Health FIDA Plan will pay for peer mentoring for Participants who have recently transitioned into the community from a nursing facility or during times of crisis. This is an individually designed service intended to improve the Participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This will be accomplished through education, teaching, instruction, information sharing, and self-advocacy training.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Personal care services (PCS) Aetna Better Health FIDA Plan will pay for PCS to assist Participants with activities such as personal hygiene, dressing, feeding, and nutritional and environmental support function tasks (meal preparation and housekeeping). PCS must be medically necessary, ordered by the Participant's physician, and provided by a qualified person according to a plan of care.	$0
Personal emergency response services (PERS) Aetna Better Health FIDA Plan will pay for PERS, which is an electronic device that enables certain high-risk Participants to reach out for help during an emergency.	$0
Personalized recovery oriented services (PROS) Aetna Better Health FIDA Plan will pay for PROS to assist individuals in recovery from the disabling effects of mental illness. This includes the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations.	$0
Pharmacy benefits (outpatient) Aetna Better Health FIDA Plan will pay for certain generic, brand, and non-prescription drugs to treat a Participant's illness or condition. Chapters 5 and 6 provide additional information about your pharmacy benefits.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Physician/provider services, including Primary Care Provider (PCP) office visits Aetna Better Health FIDA Plan will pay for the following services: ▪ Medically necessary health care or surgery services given in places such as: » physician's office » certified ambulatory surgical center » hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams given by your PCP or a specialist, if your doctor orders it to see whether you need treatment ▪ Second opinion by another network provider before a medical procedure Participants may see PCPs without first getting prior authorization.	$0
Podiatry services Aetna Better Health FIDA Plan will pay for the following services: ▪ Care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) ▪ Routine foot care for Participants with conditions affecting the legs, such as diabetes	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Positive behavioral interventions and support (PBIS) Aetna Better Health FIDA Plan will pay for PBIS for Participants who have significant behavioral difficulties that jeopardize their ability to remain in the community. The primary focus of this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. Examples of PBIS include: ▪ Comprehensive assessment of the Participant ▪ Development and implementation of a holistic structured behavioral treatment plan ▪ Training of family, natural supports, and other providers ▪ Regular reassessment of the effectiveness of the Participant's behavioral treatment plan	$0
Preventive services Aetna Better Health FIDA Plan will pay for all preventive tests and screenings covered by Medicare and Medicaid to help prevent, find, or manage a medical problem. This includes, but is not limited to, all the preventive services listed in this chart. You will see this apple next to preventive services in the benefits chart.	$0
Private duty nursing services Aetna Better Health FIDA Plan will pay for private duty nursing services covered for continuous or intermittent skilled nursing services. These services are provided in the Participant's home and are beyond what a certified home health agency can provide.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Prostate cancer screening exams For men age 50 and older, Aetna Better Health FIDA Plan will pay for the following services once every 12 months: ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test This service does not require prior authorization.	$0
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. Aetna Better Health FIDA Plan will pay for the following prosthetic devices, and maybe other devices not listed here: ▪ 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) ▪ Orthotic appliances and devices ▪ Support stockings ▪ Orthopedic footwear Aetna Better Health FIDA Plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.	$0
Pulmonary rehabilitation services Aetna Better Health FIDA Plan will pay for pulmonary rehabilitation programs for Participants who have moderate to very severe chronic obstructive pulmonary disease (COPD). The Participant must have an order approved by the IDT or Aetna Better Health FIDA Plan for pulmonary rehabilitation from the provider treating the COPD.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Residential addiction services Aetna Better Health FIDA Plan will pay for addiction treatment services delivered by an approved residential program.	$0
Respiratory care services Aetna Better Health FIDA Plan will pay for respiratory therapy, which is an individually designed service provided in the home. Respiratory therapy includes preventive, maintenance, and rehabilitative airway-related techniques and procedures.	$0
Respite care services Aetna Better Health FIDA Plan will pay for respite care services to provide scheduled relief to non-paid supports who provide primary care and support to a Participant. The service may be provided in a 24-hour block of time as required. The primary location for this service is in the Participant's home, but respite services may also be provided in another community dwelling or facility acceptable to the Participant.	$0
Sexually transmitted infections (STIs) screening and counseling Aetna Better Health FIDA Plan will 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 PCP or other primary care practitioner must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. Aetna Better Health FIDA Plan will 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. Aetna Better Health FIDA Plan will pay for these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor's office. This service does not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Skilled nursing facility care Aetna Better Health FIDA Plan covers an unlimited number of days of Skilled Nursing Facility Care and there is no prior hospital stay required. Aetna Better Health FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ 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 You will 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 Aetna Better Health FIDA Plan 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 lives at the time you leave the hospital	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Smoking and tobacco cessation (counseling to stop smoking or tobacco use) If you use tobacco but do not have signs or symptoms of tobacco-related disease, you use tobacco and have been diagnosed with a tobacco-related disease, or you are taking medicine that may be affected by tobacco: ▪ Aetna Better Health FIDA Plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. Aetna Better Health FIDA Plan will pay for smoking cessation counseling for pregnant women and women up to six months after birth. This smoking cessation counseling is in addition to benefits for prescriptions and over-the-counter smoking cessation products. This service does not require prior authorization.	$0
Social and environmental supports Aetna Better Health FIDA Plan will pay for services and items to support a Participant's medical needs. Services may include: ▪ Home maintenance tasks ▪ Homemaker/chore services ▪ Housing improvement ▪ Respite care	$0
Social day care Aetna Better Health FIDA Plan will pay for social day care for functionally impaired Participants for less than 24 hours per day. The services included in this benefit provide Participants with socialization, supervision and monitoring, personal care, and nutrition in a protective setting.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Social day care transportation Aetna Better Health FIDA Plan will pay for transportation between a Participant's home and the social day care facilities.	$0
Structured day program Aetna Better Health FIDA Plan will pay for structured day program services provided in an outpatient congregate setting or in the community. Services are designed to improve or maintain the Participant's skills and ability to live as independently as possible in the community. Services may include: ▪ Assessment ▪ Training and supervision to an individual with self-care ▪ Task completion ▪ Communication skills ▪ Interpersonal skills ▪ Problem-solving skills ▪ Socialization ▪ Sensory/motor skills ▪ Mobility ▪ Community transportation skills ▪ Reduction/elimination of maladaptive behaviors ▪ Money management skills ▪ Ability to maintain a household	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Substance abuse services: Opioid treatment services Aetna Better Health FIDA Plan will pay for opioid treatment services to help Participants manage addiction to opiates such as heroin. Opioid treatment programs administer medication, generally methadone by prescription, along with a variety of other clinical services. These programs help Participants control the physical problems associated with opiate dependence and provide the opportunity for Participants to make major lifestyle changes over time. This service does not include Methadone Maintenance, which is available through Medicaid but not through Aetna Better Health FIDA Plan.	$0
Substance abuse services: Outpatient medically supervised withdrawal Aetna Better Health FIDA Plan will pay for medical supervision of Participants that are: ▪ Undergoing mild to moderate withdrawal ▪ At risk of mild to moderate withdrawal ▪ Experiencing non-acute physical or psychiatric complications associated with their chemical dependence Services must be provided under the supervision and direction of a licensed physician.	$0
Substance abuse services: Outpatient substance abuse services Aetna Better Health FIDA Plan will pay for outpatient substance abuse services including individual and group visits. Participants may directly access one assessment from a network provider in a twelve (12) month period without getting prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Substance abuse services: Substance abuse program Aetna Better Health FIDA Plan will pay for substance abuse program services to provide individually designed interventions to reduce/ eliminate the use of alcohol and/or other substances by the Participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.	$0
Telehealth services Aetna Better Health FIDA Plan will pay for telehealth services for Participants with conditions that require frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services to reduce the need for in-office visits. Participants eligible for this service include those with the following conditions: congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. These services do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Transportation services (emergency and non-emergency) Aetna Better Health FIDA Plan will pay for emergency and non-emergency transportation. Transportation is provided for medical appointments and services. Transportation is also available for non-medical events or services, such as religious services, community activities, or supermarkets, through transportation modes including but not limited to: ▪ Taxi ▪ Bus ▪ Subway ▪ Van ▪ Medical transport ▪ Ambulance ▪ Fixed wing or airplane transport ▪ Invalid coach ▪ Livery ▪ Other means	$0
Urgently needed care *Urgently needed care* is care given to treat: ▪ a non-emergency, or ▪ a sudden medical 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 cannot get to a network provider. Urgent care does not include primary care services or services provided to treat an emergency medical condition. Urgently needed care is only covered within the United States and its territories. These services do not require prior authorization.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Vision care: Eye and vision exams and eye care Aetna Better Health FIDA Plan will pay for the diagnosis and treatment of visual defects, eye disease, and eye injury. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Examinations for refraction are limited to every two (2) years unless medically necessary. For people at high risk of glaucoma, Aetna Better Health FIDA Plan will 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 older, and ▪ Hispanic Americans who are 65 or older. Article 28 Clinic services may be directly accessed without prior authorization from Aetna Better Health FIDA Plan or your IDT.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Vision Care: Eyeglasses (lenses and frames) and contact lenses Aetna Better Health FIDA Plan will pay for eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services, when authorized by an optometrist or ophthalmologist. Coverage also includes the repair or replacement of parts. Eyeglasses and contact lenses are provided once every two years unless it is medically necessary to have them more frequently or unless the glasses or contact lenses are lost, damaged or destroyed. Aetna Better Health FIDA Plan will 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.) Aetna Better Health FIDA Plan will also pay for corrective lenses, frames, and replacements if you need them after a cataract removal without a lens implant. Article 28 Clinic services may be directly accessed without prior authorization from Aetna Better Health FIDA Plan or your IDT.	$0
"Welcome to Medicare" Preventive Visit Aetna Better Health FIDA Plan covers 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. **Important:** 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.	$0

Services that Aetna Better Health FIDA Plan pays for	What you must pay
Wellness counseling Aetna Better Health FIDA Plan will pay for wellness counseling to help medically stable Participants maintain their optimal health status. A Registered Professional Nurse (RN) works with the Participant to reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. The RN is also able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol. The RN can help the Participant to identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder. These services do not require prior authorization.	$0

E. Benefits covered outside of Aetna Better Health FIDA Plan

The following four services are not covered by Aetna Better Health FIDA Plan but are available through Medicare or Medicaid. Your Interdisciplinary Team (IDT) will help you access these services.

Day treatment

Day treatment is a combination of diagnostic, treatment, and rehabilitative procedures that provide the services of the clinic treatment program, as well as social training, task and skill training, and socialization activities.

Freestanding birth center services

Services at freestanding birth centers are covered by Medicaid.

Out of network family planning services

Out of network family planning services are paid directly by Medicaid. Services include diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases, and screening for disease and pregnancy. Also included is HIV counseling and testing when provided as part of a family planning visit. Additionally, reproductive health care includes coverage of all medically necessary abortions. Fertility services are not covered.

Methadone Maintenance Treatment Program (MMTP)

MMTP consists of drug detoxification, drug dependence counseling, and rehabilitation services, which include chemical management of the patient with methadone. This does not include opioid treatment services, which are covered by Aetna Better Health FIDA Plan (see the Covered Items and Services Chart above). Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services (OASAS) under Title 14 NYCRR, Part 828.

Directly observed therapy for tuberculosis (TB)

Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to ensure patient compliance with the physician's prescribed medication regimen. While the clinical management of TB is covered under Aetna Better Health FIDA Plan, TB/DOT is covered by Medicaid when provided by an approved TB/DOT provider.

Hospice Services

Hospice services provided to Participants by Medicare approved hospice providers are paid directly by Medicare. Hospice is a coordinated program of home and inpatient care that provides non-curative medical and support services. A Participant has the right to elect hospice if his/her provider and hospice medical director determine that the Participant has a terminal prognosis. This means that the Participant has a terminal illness and is expected to have six months or less to live. Hospice programs provide Participants and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospices are organizations which must be certified under Article 40 of the New York State Public Health Law and approved by Medicare. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by Federal and State requirements. All services must be provided according to a written plan of care, which must be incorporated into the Person-Centered Service Plan (PCSP) and reflect the changing needs of the Participant/family.

If a Participant in the FIDA Plan gets Hospice services, he or she may remain enrolled and continue to access the FIDA Plan's benefit package. See the Covered Items and Services Chart in Section D of this chapter for more information about what Aetna Better Health FIDA Plan pays for while you are getting hospice care services. Hospice services and services covered by Medicare Parts A and B that relate to the Participant's terminal prognosis are paid for by Original Medicare.

For hospice services and services covered by Medicare Part A or B that relate to a Participant's terminal prognosis:

- The hospice provider will bill Medicare for a Participant's services. Medicare will pay for hospice services related to your terminal prognosis. Participants pay nothing for these services.

For services covered by Medicare Part A or B that are not related to a Participant's terminal prognosis (except for emergency care or urgently needed care):

- The provider will bill Medicare for a Participant's services. Medicare will pay for the services covered by Medicare Part A or B. Participants pay nothing for these services.

For drugs that may be covered by Aetna Better Health FIDA Plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5.

Note: If you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Call your Care Manager at **1-855-494-9945** (TTY: **711**).

F. Benefits *not* covered by Aetna Better Health FIDA Plan, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by Aetna Better Health FIDA Plan. *Excluded* means that Aetna Better Health FIDA Plan does not pay for these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by Aetna Better Health FIDA Plan under any conditions and some that are excluded by Aetna Better Health FIDA Plan only in some cases.

Aetna Better Health FIDA Plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Participant Handbook*) except under the specific conditions listed. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Covered Items and Services Chart, **the following items and services are not covered by Aetna Better Health FIDA Plan:**

- Services considered not medically necessary according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by Aetna Better Health FIDA Plan. See Chapter 3, page 41 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 it is medically needed and Medicare pays for it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a 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 needed.
- 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, Aetna Better Health FIDA Plan will 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 Medicare coverage guidelines.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

- Radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids.
- 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. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under Aetna Better Health FIDA Plan, we will reimburse the veteran for the difference. Participants are still responsible for their cost sharing amounts.

Chapter 5: Getting your outpatient prescription drugs and other covered medications through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs and other covered medications*. 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 Medicaid.

Aetna Better Health FIDA Plan also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some 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, see the Covered Items and Services Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. A written prescription is required for both prescription and over-the-counter (OTC) drugs.
2. You generally must use a network pharmacy to fill your prescription unless Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) has authorized you to use an out-of-network pharmacy.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See page 161 to learn about asking for an exception.
4. Your drug must be used for a *medically accepted indication*. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan Participants. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

Show your Participant ID Card when you fill a prescription

To fill your prescription, **show your Participant ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription or over-the-counter (OTC) drug.

If you do not have your Participant ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up*. You can then ask Aetna Better Health FIDA Plan to pay you back. If you cannot pay for the drug, contact Participant Services right away. We will do what we can to help.

➔ To learn how to ask us to pay you back, see Chapter 7.

➔ If you need help getting a prescription filled, you can contact Participant Services or your Care Manager.

What if you want to change to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy.

➔ If you need help changing your network pharmacy, you can contact Participant Services or your Care Manager.

What if the pharmacy you use leaves the network?

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

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility. Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must 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 any difficulty accessing your drug benefits in a long-term care facility, please contact your Care Manager or Participant 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 supply drugs requiring special handling and instructions on their use.

→ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

Can you use mail-order services to get your drugs?

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

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

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, talk to your Care Manager or call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

Usually, a mail-order prescription will get to you within 10 days. If a mail order is delayed by the mail order pharmacy, they will contact you and help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local pharmacy. If you have not received an order within 10 calendar days of when you sent the order, call CVS Caremark Customer Care at 1-800-552-8159 (hearing impaired only, TTY 1-800-231-4403) and they will begin processing a replacement order. The order will be quickly sent to you. Calls to this number are free.

How will the mail-order service process my prescription?

The 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 will automatically fill and deliver new prescriptions it gets from you.

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

The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail order services with this 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 choosing the option on the CVS Caremark website at www.caremark.com. If you need help, you can contact your Care Manager or call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Participant Services or your Care Manager and let us know how you would like us to receive your mail order prescriptions or by registering online with CVS Caremark at www.caremark.com. You can change your mail order preference at any time.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, 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, please contact us by calling Participant Services or your Care Manager. You can also change your preferences by registering online with CVS Caremark at www.caremark.com.

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Contact CVS Caremark Customer Care at 1-800-552-8159 (hearing impaired only, TTY 1-800-231-4403) to tell them the best way to reach you. If we don't know the best way to reach you, you might miss the chance to tell us whether you want a refill and you could run out of your prescription drugs.

Can you get a long-term supply of drugs?

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

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 Participant Services or your Care Manager for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a Participant of our plan.

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

- If you get prescriptions with emergency care.
- If you get prescriptions with urgently needed care when network pharmacies are not available.
- If you are unable to get a covered prescription drug in a timely manner within our service area because there is no 24-hour network pharmacy within a reasonable driving distance.
- If you try to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).
- If you travel outside your service area (within the United States) and run out of your medication, lose your medication or become ill and cannot access a network pharmacy.

- If you have not received your prescription during a declared state or federal disaster or other declared public health emergency in which you are evacuated or displaced from your service area or place of residence.
- Out-of-network supply is limited to 29 day-supply.
- Paper claims should be submitted for reimbursement.

➔ In these cases, please check first with Participant Services to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription at a pharmacy not in the plan's network?

Sometimes a pharmacy that is not in the plan's network will require you to pay the full cost for the drug and seek payment from us. You can ask Aetna Better Health FIDA Plan to pay you back.

➔ To learn more about this, see Chapter 7.

B. The plan's Drug List

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and items covered under your Medicaid benefits.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Participant Services or your Care Manager.

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

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.

- Visit the plan's website at **www.aetnabetterhealth.com/newyork**. The Drug List on the website is always the most current one.
- Call Participant Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs or all over-the-counter (OTC) drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Aetna Better Health FIDA Plan will *not* pay for the drugs listed in this section. These are called *excluded drugs*. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Aetna Better Health FIDA Plan for free, but they are not considered part of your outpatient prescription drug benefits.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use*. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are tiers?

Every drug on the plan's Drug List is in one of 3 tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs.)

- Tier 1: Part D prescription generic drugs
- Tier 2: Part D prescription brand name drugs
- Tier 3: Non-Part D prescription and over-the-counter drugs

To find out which tier your drug is in, look for the drug in the plan's Drug List.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription and covered over-the-counter (OTC) drugs, special rules limit how and when the plan covers them. In general, 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 will work just as well as a higher-cost drug, the plans expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that the prescribing provider will have to give us or your Interdisciplinary Team (IDT) extra information, or you or your provider will have to 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 the rule should not apply to your situation, you should ask Aetna Better Health FIDA Plan or your IDT to make an exception. Aetna Better Health FIDA Plan or your IDT may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, if there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us or your IDT the medical reason that the generic drug and other covered drugs that treat the same condition will not work for you and has written "DAW" (Dispense as Written) on your prescription for a brand-name drug, then Aetna Better Health FIDA Plan or your IDT will approve the brand-name drug.

2. Getting plan or IDT approval in advance

For some drugs, you or your doctor must get approval from the plan or your IDT before you fill your prescription. If you don't get approval, we may not cover the drug. Your IDT may approve drugs as part of your Person-Centered Service Plan (PCSP), or you can ask Aetna Better Health FIDA Plan for approval.

During the first 90 days of your membership in the plan, you do not need the plan or your IDT to approve a refill request for an existing prescription, even if the drug is not on our Drug List or is limited in some way. See page 113 for more information about getting a temporary supply.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers 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, Aetna Better Health FIDA Plan's rules may require you to try Drug A first. If Drug A does not work for you, the plan will then 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, the plan might limit how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Participant Services or check our website at **www.aetnabetterhealth.com/newyork**.

D. Why your drug might not be covered

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

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask Aetna Better Health FIDA Plan or your IDT to approve the drug.

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

1. **The drug you have been taking:**
   - is no longer on the plan's Drug List, ***or***
   - was never on the plan's Drug List, ***or***
   - is now limited in some way.
2. **You must be in one of these situations:**
   - **You were in the plan last year and do not live in a long-term care facility.**

     We will cover a temporary supply (or supplies) of your drug **during the first 90 days of the calendar year**. This temporary supply or supplies will be for up to 90 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 90 days of medication. You must fill the prescription at a network pharmacy.
   - **You are new to the plan and do not live in a long-term care facility.**

     We will cover a temporary supply (or supplies) of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for up to 90 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 90 days of medication. You must fill the prescription at a network pharmacy.
   - **You were in the plan last year and live in a long-term care facility.**

     We will cover a temporary supply (or supplies) of your drug **during the first 90 days of the calendar year**. The total supply will be for up to up to 98 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 98 days of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
   - **You are new to the plan and live in a long-term care facility.**

     We will cover a temporary supply (or supplies) of your drug **during the first 90 days of your membership** in the plan. The total supply will be for up to up to 98 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 98 days of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **You are a current member and have a change in level of care**

  We will cover up to a one time temporary 30-day supply if you move from the hospital to a home setting and:

  - You need a drug that is not on our drug list, ***and***
  - Your ability to get the drug is limited

  We will cover a one time temporary 31-day supply (see the note below for exceptions) if you move into or out of a long-term care setting and:

  - You need a drug that is not on our drug list, ***and***
  - Your ability to get the drug is limited

  Note: Oral brand name solid dosage form such as tablets or capsules are limited to 14 day fills with exceptions as required by Medicare Part D rules. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

  During this period, you should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

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

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

- **You can change to another drug.**
  There may be a different drug covered by the plan that works for you. You can call Participant Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- **You can ask for an exception.**
  You and your provider can ask Aetna Better Health FIDA Plan or your IDT to make an exception. For example, you can ask Aetna Better Health FIDA Plan or your IDT to approve a drug even though it is not on the Drug List. Or you can ask Aetna Better Health FIDA Plan or your IDT to approve and cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

➔ To learn more about asking for an exception, see Chapter 9.

➔ If you need help asking for an exception, you can contact Participant Services or your Care Manager.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

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

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

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

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - » You should work with your Care Manager or your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - » You and your Care Manager or your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - » Your Care Manager and your provider will also know about this change. He or she can work with you to find another drug for your condition.

→ If there is a change to coverage for a drug you are taking, **the plan will send you a notice**. Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are 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 its residents. If you are living 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, please contact your Care Manager or Participant Services.

If you are in a long-term care facility and become a new Participant of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply or multiple temporary supplies up to 98 days when you ask for a refill during the first 90 days of your membership.

If you have been a Participant of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your Care Manager or your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your Care Manager or your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

→ To learn more about asking for exceptions, see Chapter 9.

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting any unrelated drugs that should be covered by our plan, 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 should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

→ To learn more about the hospice benefit, see Chapter 4.

G. Programs on drug safety and managing drugs

Programs to help Participants use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will notify your Care Manager and have your Interdisciplinary Team (IDT) work with your provider to correct the problem.

Programs to help Participants manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all 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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to Participants that qualify. If we have a program that fits your needs, your Interdisciplinary Team (IDT) will discuss whether you should enroll in the program.

➔ If you have any questions about these programs, please contact Participant Services or your Care Manager.

Chapter 6: Understanding the plan's drug coverage

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Introduction

This chapter discusses your outpatient drug coverage through Aetna Better Health FIDA Plan. By "drugs," we mean:

- Medicare Part D prescription drugs, ***and***
- drugs and items covered under Medicaid, ***and***
- drugs and items covered by the plan as additional benefits.

Because you are enrolled in the Fully Integrated Duals Advantage (FIDA) Demonstration, you have **no costs** for any covered drugs.

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

- **Aetna Better Health FIDA Plan's *List of Covered Drugs*.** We call this the "Drug List." It tells you:
  - » Which drugs Aetna Better Health FIDA Plan pays for
  - » Which of the 3 tiers each drug is in
  - » Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Participant Services. You can also find the Drug List on our website at **www.aetnabetterhealth.com/newyork**. The Drug List on the website is always the most current.
- **Chapter 5 of this Participant Handbook.** Chapter 5 tells how to get your outpatient prescription drugs through Aetna Better Health FIDA Plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by Aetna Better Health FIDA Plan.
- **Aetna Better Health FIDA Plan's *Provider and Pharmacy Directory*.** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with Aetna Better Health FIDA Plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.

A. The Explanation of Benefits (EOB)

Aetna Better Health FIDA Plan keeps track of your drugs and your total drug costs, including the amount Medicare pays for you.

When you get prescription drugs through Aetna Better Health FIDA Plan, we send you a report called the *Explanation of Benefits*. We call it the *EOB* for short. The EOB includes:

- **Information for the month.** The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what Medicare paid for you. The EOB is not a bill. It is just for your records.
- **"Year-to-date" information.** These are your drugs used during the year and the total payments made by Aetna Better Health FIDA Plan and Medicare for you since January 1.

→ We offer coverage of drugs not covered under Medicare. We also pay for some over-the-counter drugs. To find out which drugs Aetna Better Health FIDA Plan covers, see the Drug List.

B. Keeping track of your drugs

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 Participant ID Card.

Show your Aetna Better Health FIDA Plan **Participant** ID Card every time you get a prescription filled. This will help us know what prescriptions you fill.

2. Make sure we have the information we need if we need to reimburse you.

You should not have to pay for any covered drugs under Aetna Better Health FIDA Plan. In the event of a mix-up at the pharmacy or some other reason that you end up paying for a covered drug, give us copies of receipts. 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 Aetna Better Health FIDA 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

→ To learn how to ask us to pay you back for the drug, see Chapter 7.

3. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Participant Services. Be sure to keep these reports.

C. A summary of your drug coverage

The plan's tiers

Tiers are groups of drugs. Every drug on the plan's Drug List is in one of 3 tiers. There is no cost to you for drugs on any of the tiers.

- Tier 1: Part D prescription generic drugs
- Tier 2: Part D prescription brand name drugs
- Tier 3: Non-Part D prescription and over-the-counter drugs

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 90-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, see Chapter 5 or the *Provider and Pharmacy Directory*.

Your coverage for a one-month or long-term supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 90-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 98-day supply	**An out-of-network pharmacy** Up to a 29-day supply. Coverage is limited to certain cases. See Chapter 5 for details.
Tier 1 (Part D prescription generic drugs)	$0	$0	$0	$0
Tier 2 (Part D prescription brand name drugs)	$0	$0	$0	$0
Tier 3 (Non-Part D prescription and over-the-counter drugs)	$0	$0	$0	$0

→ For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory*.

D. Vaccinations

Aetna Better Health FIDA Plan covers Medicare Part D vaccines. There are no costs for vaccinations that are covered under Aetna Better Health FIDA Plan.

Before you get a vaccination

We recommend that you talk to your Care Manager whenever you would like to get a vaccination. Your Interdisciplinary Team (IDT) will discuss appropriate vaccinations.

It is best to use a network provider and pharmacy to get your vaccinations. If you are not able to use a network provider and pharmacy, you may have to pay the entire cost for both the vaccine itself and for getting the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your provider. If you are in this situation, we recommend that you call your Care Manager first. If you pay the full cost of the vaccine at a provider's office, we can tell you how to ask us to pay you back.

→ To learn how to ask us to pay you back, see Chapter 7.

Chapter 7: Asking us to pay a bill you have gotten for covered services, items, or drugs

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A. When can you ask Aetna Better Health FIDA Plan to pay for your services, items, or drugs?

You should not get a bill for any in-network services, items, or drugs. Our network providers must bill Aetna Better Health FIDA Plan for the services, items, and drugs you already got. A *network provider* is a provider who works with the FIDA Plan.

If you get a bill for health care or drugs, do not pay the bill. Instead, send the bill to Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT). To send Aetna Better Health FIDA Plan or your IDT a bill, see page 125.

- If the services, items, or drugs are covered, Aetna Better Health FIDA Plan will pay the provider directly.
- If the services, items, or drugs are covered and you already paid the bill, it is your right to be paid back.
- If the services, items, or drugs are **not** covered, Aetna Better Health FIDA Plan or your IDT will tell you. You may appeal the decision.

→ Contact Participant Services or your Care Manager if you have any questions. If you get a bill and you do not know what to do about it, Participant Services can help. You can also call if you want to give more information about a request for payment you already sent to Aetna Better Health FIDA Plan or your IDT.

→ The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance about your FIDA Plan coverage and rights. To contact ICAN, call 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Here are examples of times when you may get a bill and may need to ask Aetna Better Health FIDA Plan or your IDT to decide if the plan will pay you back or pay the bill that you got:

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

You should ask the provider to bill Aetna Better Health FIDA Plan.

- If you pay the full amount when you get the care, ask us to pay you back. Send Aetna Better Health FIDA Plan or your IDT the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send Aetna Better Health FIDA Plan or your IDT the bill and proof of any payment you made.
  - » If the provider should be paid, Aetna Better Health FIDA Plan will pay the provider directly.
  - » If you have already paid for the service, Aetna Better Health FIDA Plan will pay you back.

2. When a network provider sends you a bill

Network providers must always bill Aetna Better Health FIDA Plan.

- Whenever you get a bill from a network provider, send us the bill. Aetna Better Health FIDA Plan will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send Aetna Better Health FIDA Plan or your IDT the bill and proof of any payment you made. Aetna Better Health FIDA Plan will pay you back for your covered services, items, and drugs.

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

If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

→ In some cases, Aetna Better Health FIDA Plan or your IDT will approve prescriptions filled at out-of-network pharmacies. Send Aetna Better Health FIDA Plan or your IDT a copy of your receipt when you ask Aetna Better Health FIDA Plan to pay you back. Please see Chapter 5 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Aetna Better Health FIDA Plan Participant ID Card with you

If you do not have your Participant ID Card with you, you can ask the pharmacy to call Aetna Better Health FIDA Plan or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.

- Send Aetna Better Health FIDA Plan or your IDT a copy of your receipt when you ask Aetna Better Health FIDA Plan to pay you back.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on Aetna Better Health FIDA Plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - » If you do not pay for the drug but think it should be covered, you can ask for a coverage decision from Aetna Better Health FIDA Plan or your IDT (see Chapter 9).
  - » If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision from Aetna Better Health FIDA Plan or your IDT (see Chapter 9).
- Send Aetna Better Health FIDA Plan or your IDT a copy of your receipt when you ask for Aetna Better Health FIDA Plan to pay you back. In some situations, Aetna Better Health FIDA Plan or your IDT may need to get more information from your doctor or other prescriber in order for Aetna Better Health FIDA Plan to pay you back for the drug.

When you send Aetna Better Health FIDA Plan or your IDT a request for payment, your request will be reviewed and a decision will be made as to whether the service, item, or drug should be covered. This is called making a "coverage decision." If Aetna Better Health FIDA Plan or your IDT decides it should be covered, Aetna Better Health FIDA Plan will pay for the service, item, or drug. If Aetna Better Health FIDA Plan or your IDT denies your request for payment, you can appeal the decision.

➔ To learn how to make an appeal, see Chapter 9.

B. How and where to send your request for payment

Send Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your Care Manager for help.

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

Aetna Better Health FIDA Plan
Attn: Participant Services
55 West 125th Street, Suite 1300
New York, NY 10027

You may also call Aetna Better Health FIDA Plan to ask for payment. Call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

C. Aetna Better Health FIDA Plan or your IDT will make a coverage decision

When Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) gets your request for payment, it will be reviewed and a *coverage decision* will be made. This means that Aetna Better Health FIDA Plan or your IDT will decide whether your health care or drug is covered by the plan. Aetna Better Health FIDA Plan or your IDT will also decide the amount, if any, you have to pay for the health care or drug.

- Aetna Better Health FIDA Plan or your IDT will let you know if it needs more information from you.
- If Aetna Better Health FIDA Plan or your IDT decides that the service, item, or drug is covered and you followed all the rules, the plan will pay for it. If you have already paid for the service, item, or drug, Aetna Better Health FIDA Plan will mail you a check for what you paid. If you have not paid for the service, item, or drug yet, Aetna Better Health FIDA Plan will pay the provider directly.

➔ Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If Aetna Better Health FIDA Plan or your IDT decides the plan should not to pay for the service, item, or drug, the plan will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

➔ To learn more about coverage decisions, see Chapter 9.

D. You can appeal the coverage decision

If you think Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) made a mistake in turning down your request for payment, you can ask Aetna Better Health FIDA Plan to change the decision. This is called *making an appeal*. You can also make an appeal if you do not agree with the amount Aetna Better Health FIDA Plan or your IDT decides that the plan will pay.

➔ The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9.

- If you want to make an appeal about getting paid back for a service or item, go to page 158.
- If you want to make an appeal about getting paid back for a drug, go to page 158.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any appeals you may file with Aetna Better Health FIDA Plan. To contact ICAN, call 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Chapter 8: Your rights and responsibilities

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Introduction

In this chapter, you will find your rights and responsibilities as a Participant of Aetna Better Health FIDA Plan. Aetna Better Health FIDA Plan must honor your rights.

A. You have a right to get information in a way that meets your needs

We must tell you about Aetna Better Health FIDA Plan benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are a Participant in Aetna Better Health FIDA Plan. We must also tell you about all of your rights and how to exercise your rights in writing prior to the effective date of coverage.

You have the right to get timely information about Aetna Better Health FIDA Plan changes. This includes the right to get annual updates to the Marketing, Outreach and Participant Communications materials. This also means you have the right to get notice of any significant change in the way in which services are provided to you at least 30 days prior to the intended effective date of the change.

You have the right to have all plan options, rules, and benefits fully explained, including through the use of a qualified interpreter if needed. To get information in a way that you can understand, please call Participant Services. Aetna Better Health FIDA Plan has people who can answer questions in different languages.

Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. Written materials are available in Spanish, Chinese, Russian, Italian, Haitian-Creole and Korean. If you wish to make a standing request to receive all materials in a language other than English or in an alternate format, you can call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

- If you are having trouble getting information from Aetna Better Health FIDA Plan because of language problems or a disability and you want to file a grievance, 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. You can also file a complaint with the New York State Department of Health at any time. You can call them at 1-800-206-8125.

B. We must treat you with respect, fairness, and dignity at all times

Aetna Better Health FIDA Plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate against Participants because of any of the following:**

- Age
- Appeals
- Behavior
- Claims experience
- Color
- Ethnicity
- Evidence of insurability
- Genetic information
- Gender identity
- Geographic location within the service area
- Health status
- Marital status
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of health care
- Religion
- Sex
- Sexual orientation
- Use of services

Under the rules of Aetna Better Health FIDA Plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation. You have the right to not be neglected, intimidated, physically or verbally abused, mistreated, or exploited. You also have the right to be treated with consideration, respect, and full recognition of your dignity, privacy, and individuality.

We cannot deny services to you or punish you for exercising your rights. Your exercising of your rights will not negatively affect the way Aetna Better Health FIDA Plan and its providers, New York State, or CMS provide or arrange for the provision of services to you.

→ For more information, or if you 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 call 1-800-537-7697). You can also visit http://www.hhs.gov/ocr for more information.

→ You can also call your local Office for Civil Rights. You can contact the Civil Rights Bureau of the New York State Attorney General's Office at 212-416-8250.

→ If you have a disability and need help getting care or reaching a provider, call Participant Services. If you have a grievance, such as a problem with wheelchair access, Participant Services can help. You can reach Participant Services at **1-855-494-9945**, 24 hours a day, 7 days a week. TTY users call **711**.

C. We must ensure that you get timely access to covered services, items, and drugs

As a Participant of Aetna Better Health FIDA Plan these are your rights:

- You have the right to get medically necessary services, items, and drugs as required to meet your needs, in a way that is sensitive to your language and culture, and that is provided in an appropriate care setting, including the home and community.
- You have the right to choose a Primary Care Provider (PCP) in Aetna Better Health FIDA Plan's network. A *network provider* is a provider who works with Aetna Better Health FIDA Plan. You can also ask us to have a specialist serve as your PCP.
  - » Call Participant Services or look in the *Provider and Pharmacy Directory* to learn which providers are accepting new patients.
- You have the right to make decisions about providers and coverage, which includes the right to choose and change providers within our network.
- You have the right to go to a gynecologist or another women's health specialist without getting a referral or prior authorization.
  - » A *referral* is approval from your Primary Care Provider to see another Provider. Referrals are not required in Aetna Better Health FIDA Plan.
  - » *Prior authorization* means that you must get approval from your Interdisciplinary Team (IDT), Aetna Better Health FIDA Plan, or another specified provider before you can get certain services, items, or drugs or see an out-of-network provider.
- You have the right to access other services that do not require prior authorization, such as emergency and urgently needed care, out-of-area dialysis services, and Primary Care Provider visits. Please see Chapter 4 for more information on services requiring prior authorization and those that do not.
- You have the right to get covered services from network providers within a reasonable amount of time. If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
  - » This includes the right to get timely services from specialists.
- You have the right to have telephone access to your providers through on-call services. You also have the right to access the Aetna Better Health FIDA Plan Nurse Advice Call Line 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care or assistance.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.

- You have the right to access care without facing physical barriers. This includes the right to be able to get in and out of a provider's office, including barrier-free access if you have any disabilities or other conditions limiting your mobility, in accordance with the Americans with Disabilities Act.
- You have the right to access an adequate network of primary and specialty providers who are capable of meeting your needs with respect to physical access, as well as communication and scheduling needs.
- You have the right to get reasonable accommodations in accessing care, in interacting with Aetna Better Health FIDA Plan and providers, and in getting information about your care and coverage.
- You have the right to be told where, when, and how to get the services you need, including how to get covered benefits from out-of-network providers if the providers you need are not available in Aetna Better Health FIDA Plan's network. To learn about out-of-network providers, see Chapter 3.

Chapter 9 explains what you can do if you think you are not getting your services, items, or drugs within a reasonable amount of time. Chapter 9 also tells you what you can do if we have denied coverage for your services, items, or drugs and you do not agree with our decision.

D. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- You have the right to have privacy during treatment and to expect confidentiality of all records and communications.
- Your personal health information includes the information you gave us when you enrolled in Aetna Better Health FIDA Plan. It also includes your conversations with your providers, your medical records, and other medical and health information.
- You have the right to get information and to control how your health information is used. We give you a written notice called the "Notice of Privacy Practices" that tells about these rights. The notice also explains how we protect the privacy of your health information.
- You have the right to ask that any communication that contains protected health information from Aetna Better Health FIDA Plan be sent by alternative means or to an alternative address.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first*. Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - » We are required to release health information to government agencies that are checking on our quality of care.
  - » We are required to give Medicare and Medicaid your health and drug information. If Medicare or Medicaid releases your information for research or other uses, it will be done according to Federal laws. You have the right to ask for information on how your health and other information has been released by Aetna Better Health FIDA Plan.

You have a right to see 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 will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your health information has been shared with others.

→ If you have questions or concerns about the privacy of your personal health information, call Participant Services at **1-855-494-9945**, 24 hours a day, 7 days a week. TTY users call **711**.

E. We must give you information about Aetna Better Health FIDA Plan, its network providers, and your covered services

As a Participant of Aetna Better Health FIDA Plan, you have the right to get timely information and updates from us. If you do not speak English, we must give you the information free of charge in a language that you can understand. We must also provide you with a qualified interpreter, free of charge, if you need one during appointments with providers. If you have questions about Aetna Better Health FIDA Plan or you are in need of interpreter services, just call us at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. This is a free service. Written materials are available in Spanish, Chinese, Russian, Italian, Haitian-Creole and Korean. We can also give you information in other formats, such as large print, braille, or audio.

If you want any of the following, call Participant Services:

- **Information about how to choose or change plans**
- **Information about Aetna Better Health FIDA Plan, including:**
  - » Financial information
  - » How Aetna Better Health FIDA Plan has been rated by plan Participants
  - » The number of appeals made by Participants
  - » How to leave Aetna Better Health FIDA Plan
- **Information about our network providers and our network pharmacies, including:**
  - » How to choose or change Primary Care Providers
  - » The qualifications of our network providers and pharmacies
  - » How we pay the providers in our network

    ➔ For a list of providers and pharmacies in Aetna Better Health FIDA Plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Participant Services, or visit our website at **www.aetnabetterhealth.com/newyork**.
- **Information about covered services, items, and drugs and about rules you must follow, including:**
  - » Services, items, and drugs covered by Aetna Better Health FIDA Plan
  - » Limits to your coverage and drugs
  - » Rules you must follow to get covered services, items, and drugs
- **Information about why a service, item, or drug is not covered and what you can do about it, including:**
  - » Asking us to put in writing why something is not covered
  - » Asking us to change a decision we made
  - » Asking us to pay for a bill you got

F. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services, items, or drugs. They also cannot charge you if we pay less than the provider charged us or if we don't pay them at all. You have the right to not be charged any copays, premiums, deductibles, or other cost-sharing. To learn what to do if a network provider tries to charge you for covered services, items, or drugs, see Chapter 7 or call Participant Services.

G. You have the right to leave Aetna Better Health FIDA Plan at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave Aetna Better Health FIDA Plan, you will still be in the Medicare and Medicaid programs as long as you are eligible. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. You also have the right to get your Medicaid services through other programs including the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus, Managed Long-Term Care, or Medicaid Fee-For-Service (Original Medicaid).

H. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your services

You have the right to get full information from your doctors and other health care providers when you get services. You also have the right to have access to doctors and other providers who can meet your needs. This includes providers who can help you meet your health care needs, communicate with you in a way that you can understand, and provide you with services in locations that you can physically access. You may also choose to have a family member or caregiver involved in your services and treatment discussions. You have the right to appoint someone to speak for you about the care you need.

- **Know your choices.** You have the right to be told about all the kinds of treatment. You have the right to talk with and get information from providers on all available treatment options and alternatives, regardless of cost, and to have these options presented in a way you understand.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another provider before deciding on treatment.

- **You can say "no."** You have the right to accept or refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your provider advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from Aetna Better Health FIDA Plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You have the right to get a written explanation.** If covered services, items, or drugs were denied, you have the right to get a written explanation without having to ask for one.
- **You can ask us to cover a service, item, or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) for a coverage decision.
- **You can participate in your care planning.** As a Participant in Aetna Better Health FIDA Plan, you will get an in-person Comprehensive Assessment within the first 90 days of your enrollment or within six months of your last assessment if you joined Aetna Better Health FIDA Plan from Aetna Better Health of New York MLTC. You will also meet with your IDT to develop your Person-Centered Service Plan (PCSP) and to update it, when necessary. You have the right to ask for a new Comprehensive Assessment or an update to your PCSP at any time. For more information, see Chapter 1.
- **You have the right to complete and accurate information related to your health and functional status from your provider, your IDT, and Aetna Better Health FIDA Plan.**

You have the 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 to **give someone the right to make health care decisions for you**.
- **Give your providers written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can 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*. When you enroll in the plan, we will inform you about your right to make an advance directive. You will also be told about this right when your Person-Centered Service Plan is updated.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your Primary Care Provider, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid (such as the New York City Department for the Aging, New York State Bar Association and AARP) may also have advance directive forms. You can also contact Participant Services to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your Primary Care Provider. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

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

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

Aetna Better Health FIDA Plan and our providers must honor your instructions. If you have signed an advance directive, and you believe that a provider did not follow the instructions in it, you may file a complaint with the New York State Department of Health Hospital Complaint Line at 1-800-804-5447 or the Managed Long Term Care Technical Assistance Center at 1-866-712-7197.

I. You have the right to ask for help

Chapter 2 contains contact numbers for many helpful resources. You have the right to ask for help without interference from Aetna Better Health FIDA Plan. You can ask for help from agencies like the Independent Consumer Advocacy Network (ICAN) or the NY State Long Term Care Ombudsman.

- ICAN can provide information and assistance related to your Aetna Better Health FIDA Plan coverage. ICAN can be reached at 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.)
- The NY State Long Term Care Ombudsman can provide information and assistance about your rights as a resident of a long-term care facility. Call 1-800-342-9871 for information about contacting your local long-term care ombudsman.

There are other resources available to you, including those listed in Chapter 2. You have the right to ask for help from the entities listed in Chapter 2 or from any other entity you identify.

J. You have the right to file a grievance and to ask us to reconsider decisions we have made

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

You have the right to get information about appeals and grievances that other Participants have filed against Aetna Better Health FIDA Plan. To get this information, call Participant Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly – and it is *not* about discrimination for the reasons listed on page 129 – you can get help in these ways:

- You can **call Participant Services** and file a grievance with Aetna Better Health FIDA Plan as outlined in Chapter 9.
- You can **call the Health Insurance Information, Counseling and Assistance Program (HIICAP)** at 1-800-701-0501.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You can **call Medicaid** at 1-800-541-2831. TTY users call 1-877-898-5849.
- You can **call the Independent Consumer Advocacy Network (ICAN)** at 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Under all circumstances, you have the right to file an internal grievance with Aetna Better Health FIDA Plan, an external grievance with Medicare or the New York State Department of Health (NYSDOH), or an appeal of any coverage decision. The processes for filing any of these are outlined in Chapter 9.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can **call Participant Services**.
- You can **call the Health Insurance Information, Counseling and Assistance Program (HIICAP)** at 1-800-701-0501.
- You can **contact Medicare**.
  - » You can visit the Medicare website to read or download "Medicare Rights & Protections." (Go to https://www.medicare.gov/Pubs/pdf/02226.pdf.)
  - » Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You can **call Medicaid** at 1-800-541-2831. TTY users call 1-877-898-5849.
- You can **call the Independent Consumer Advocacy Network (ICAN**) at 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

How to get help understanding your rights or exercising them

You can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.) ICAN provides free information and assistance. It is not affiliated with our plan.

K. You have the right to suggest changes

You have the right to recommend changes in policies and services to Aetna Better Health FIDA Plan, Medicare, the New York State Department of Health, or any outside representative of your choice.

L. You also have responsibilities as a Participant of Aetna Better Health FIDA Plan

As a Participant of Aetna Better Health FIDA Plan, you have a responsibility to do the things that are listed below. If you have any questions, call Participant Services.

- **Read the *Participant Handbook* to learn what is covered and what rules you need to follow to get covered services, items, and drugs.** This includes choosing a Primary Care Provider and using network providers for covered services, items, and drugs. If you don't understand something, call Participant Services.
  - » For details about your covered services and items, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - » For details about your covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage you have.** We are required to make sure you are using all of your coverage options when you get services. Please call Participant Services if you have other coverage.
- **Tell your Primary Care Provider and other providers that you are enrolled in Aetna Better Health FIDA Plan.** Show your Aetna Better Health FIDA Plan Participant ID Card whenever you get services, items, or drugs.
- **Help your Primary Care Provider and other providers give you the best care.**
  - » Call your Primary Care Provider or Care Manager if you are sick or injured for direction right away. When you need emergency care from out-of-network providers, notify Aetna Better Health FIDA Plan as soon as possible. In case of emergency, call 911.
  - » Give your providers the 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 that your Primary Care Provider and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - » If you have any questions, be sure to ask. Your providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
  - » Understand the role of your Primary Care Provider, your Care Manager, and your Interdisciplinary Team (IDT) in providing your care and arranging other health care services that you may need.
  - » Participate in the development of your Person-Centered Service Plan (PCSP) with your IDT and keep appointments or notify your Care Manager or IDT if an appointment cannot be met.

- **Be considerate.** We expect all of our Participants to respect the rights of other Participants. We also expect you to act with respect in your Primary Care Provider's office, hospitals, other providers' offices, and when dealing with Aetna Better Health FIDA Plan employees.
- **Pay what you owe.** As an Aetna Better Health FIDA Plan Participant, you are responsible for paying the full cost of any service, items, or drugs that are not covered by the plan.

  → If you disagree with your IDT's decision or Aetna Better Health FIDA Plan's decision to not cover a service, item, or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Participant Services.
  - » **If you move *outside* of our service area, you cannot be an Aetna Better Health FIDA Plan Participant.** Chapter 1 tells about our service area. The Enrollment Broker can help you figure out whether you are moving outside our service area and can help you identify alternative Medicare and Medicaid coverage. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and Medicaid.
  - » **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have any changes in your personal information, including your income or assets.** You must provide Aetna Better Health FIDA Plan with accurate and complete information.
  - » It is important to tell us right away if you have a change in personal information such as phone number, address, marital status, additions to your family, eligibility, or other health insurance coverage.
  - » If your assets in bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, or any other assets change, please notify Participant Services and New York State.
- **Call Participant Services for help if you have any questions or concerns. Let us know about any problems immediately.**

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

What's in this chapter?

This chapter has information about coverage decisions and your grievance and appeal 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 drug that your Interdisciplinary Team (IDT) or plan has said the plan will not pay for.
- You disagree with a decision that your IDT or plan has made about your care.
- You think your covered services and items are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find information about what to do for your problem or concern.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your Interdisciplinary Team (IDT) determines are necessary for your care, whether included in your Person-Centered Service Plan (PCSP) or because a need arose outside of your PCSP. **If you are having a problem with your care, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800 for help.** This chapter explains the different options you have for different problems and complaints, but you can always call ICAN to help guide you through your problem.

Table of Contents

Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What do the legal terms mean?

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

For example, we will say:

- "Coverage decision" rather than "organization determination" or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Understanding and knowing the meaning of the proper legal terms can help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

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

You can get help from the Independent Consumer Advocacy Network

If you need help, you can always call the Independent Consumer Advocacy Network (ICAN). The state created ICAN to help you with appeals and other issues. ICAN can answer your questions and help you understand what to do to handle your problem. ICAN is not connected with us or with any insurance company or health plan. ICAN can help you understand your rights and how to share your concerns or disagreement. ICAN can also help you in communicating your concerns or disagreement with us. The toll-free phone number for ICAN is 1-844-614-8800. The services are free.

You can get help from the State Health Insurance Assistance Program

You can also call your State Health Insurance Assistance Program (SHIP). The SHIP is a state program that gets funding from the federal government. In New York State, the SHIP is called the Health Insurance Information, Counseling, and Assistance Program (HIICAP). HIICAP counselors can answer your questions and help you understand what to do to handle your problem. The HIICAP is not connected with us or with any insurance company or health plan. The HIICAP has trained counselors and services are free. The HIICAP phone number is 1-800-701-0501.

Getting help from Medicare

You can also call Medicare directly for help with problems. 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 should call 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Section 3: Problems with your coverage

Section 3.1: Deciding whether you should file an appeal or a grievance

If you have a problem or concern, you only need to read the parts of this chapter that describe the process for your type of concern. The chart below will help you find the right section of this chapter for appeals and grievances.

Is your problem or concern about your coverage? (This includes problems about whether particular services, items, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for services, items, or prescription drugs.)	
Yes. My problem is about coverage. Go to **Section 4: "Coverage decisions and appeals"** on page 146.	**No.** My problem is not about coverage. Skip ahead to **Section 10: "How to file a grievance"** on page 183.

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A *coverage decision* is an initial decision your Interdisciplinary Team (IDT), the plan, or an authorized specialist makes about your benefits and coverage or about the amount the plan will pay for your medical services, items, or drugs. The IDT, plan, or authorized specialist is making a coverage decision whenever it decides what is covered for you and how much the plan will pay. Authorized specialists include dentists, optometrists, ophthalmologists, and audiologists.

If you or your provider is not sure if a service, item, or drug is covered by the plan, either of you can ask for a coverage decision before the provider gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review a decision made by your IDT, the plan, or an authorized specialist and change it if you think a mistake was made. For example, the IDT, plan, or authorized specialist might decide that a service, item, or drug that you want is not covered. If you or your provider disagree with that decision, you can appeal.

→ **NOTE:** You are a member of your IDT. You can appeal even if you participated in the discussions that led to the coverage decision that you wish to appeal.

Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Participant Services** at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.
- Call your **Care Manager** at **1-855-494-9945** (TTY: **711**).
- Call the **Independent Consumer Advocacy Network (ICAN)** for free help. ICAN is an independent organization. It is not connected with this plan. The phone number is 1-844-614-8800.
- Call the **Health Insurance Information, Counseling, and Assistance Program (HIICAP)** for free help. The HIICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-701-0501.

- Talk to **your provider**. Your provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - » Anyone can help you request a coverage determination or an appeal.
  - » Only someone you designate in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can either complete an "Appointment of Representative" form or you can write and sign a letter indicating who you want to be your representative.
    - o To get an "Appointment of Representative" form, call Participant Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **www.aetnabetterhealth.com/newyork**. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
    - o You can write a letter and either send it to us or have the person listed in the letter as your representative send it to us.
- **You also have the right to ask a lawyer** to act for you. You may 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. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

  However, **you do not need to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section 5 on page 149** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
  - o You are not getting medical care you want, and you believe the plan covers this care.
  - o The Interdisciplinary Team (IDT), plan, or authorized specialist did not approve services, items, or drugs that your provider wants to give you, and you believe this care should be covered.
    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with an asterisk (*) are **not** covered by Part D. See Section 6 on page 160 for instructions about the Part D drug appeals process.

- You got services or items you think should be covered, but the IDT, plan, or authorized specialist decided that the plan will not pay for this care.
- You got and paid for services or items that you thought were covered, and you want the plan to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with the decision.
  - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages 169 and 176.

- **Section 6 on page 160** gives you information about Part D drugs. For example, use this section if:
  - You want to ask the plan or your IDT to make an exception to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List).
  - You want to ask the plan or your IDT to waive limits on the amount of the drug you can get.
  - You want to ask the plan or your IDT to cover a drug that requires prior approval.
  - The plan or your IDT did not approve your request or exception, and you or your provider think we should have.
  - You want to ask the plan to pay for a prescription drug you already bought. (This is asking the plan or your IDT for a coverage decision about payment.)
- **Section 7 on page 169** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8 on page 176** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Participant Services at 1-855-494-9945 (TTY: **711**), 24 hours a day, 7 days a week.

If you need other help or information, please call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800.

Section 5: Problems about services, items, and drugs (but not Medicare Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long term care services. You can also use this section for problems with drugs that are **not** covered by Part D. Drugs in the List of Covered Drugs with an asterisk (*) are **not** covered by Part D. Use Section 6 for Part D drug appeals.

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

1. **You think the plan covers a medical, behavioral health, or long-term care service you need but are not getting.**

   What you can do: You can ask your Interdisciplinary Team (IDT), the plan, or an authorized specialist to make a coverage decision. Go to Section 5.2 on page 150 for information on asking for a coverage decision. If you disagree with that coverage decision, you can file an appeal.

2. **The IDT, plan, or authorized specialist did not approve care your provider wants to give you, and you think it should have.**

   What you can do: You can appeal the decision to not approve your services. Go to Section 5.3 on page 152 for information on making an appeal.

3. **You got services or items that you think the plan covers, but the IDT, plan, or authorized specialist decided that the plan will not pay.**

   What you can do: You can appeal the decision that the plan will not pay. Go to Section 5.3 on page 152 for information on making an appeal.

4. **You got and paid for services or items you thought were covered, and you want the plan to reimburse you for the services or items.**

   What you can do: You can ask the IDT, plan, or authorized specialist to authorize the plan to pay you back. Go to Section 5.5 on page 158 for information on asking us for payment.

5. **The IDT, plan, or authorized specialist changed or stopped your coverage for a certain service, and you disagree with the decision.**

   What you can do: You can appeal the decision to change or stop the service. Go to Section 5.3 on page 152 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 169 and 176 to find out more.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health, or long-term care service

If there is a service, item, or drug that you feel you need, ask your Interdisciplinary Team (IDT), the plan, or an authorized specialist to approve that service, item, or drug for you. You can do this by contacting your Care Manager and telling him/her that you want a coverage decision. Or you can call, write, or fax us, or ask your representative or provider to contact us and ask for a coverage decision.

- You can call us at: **1-855-494-9945**, 24 hours a day, 7 days a week. TTY users call: **711**.
- You can fax us at: 1-855-264-3822
- You can write to us at: Aetna Better Health FIDA Plan
  Attn: Grievance and Appeals Department
  55 West 125th Street, Suite 1300
  New York, NY 10027

Once you've asked, the IDT, plan, or authorized specialist will make a coverage decision.

How long does it take to get a coverage decision?

It usually takes up to 3 business days after you asked. If you do not receive a decision within 3 business days, you can appeal.

→ Sometimes the IDT, plan, or authorized specialist needs more time to make a decision. In this case, you will get a letter telling you that it could to take up to 3 more calendar days. The letter will explain why more time is needed.

There are three exceptions to the decision deadline described above:

- For coverage decisions about continuing or adding to your current health care services, you will get a decision within 1 business day.
- For coverage decisions about home health care services after an inpatient hospital stay, you will get a decision within 1 business day. However, if the day after your request is a weekend or holiday, you will get a decision within 72 hours.
- For coverage decisions on a service, item, or drug that you already got, you will get a decision within 14 calendar days.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask for a "fast coverage decision." If the IDT, plan, or authorized specialist approves the request, you will get a decision within 24 hours.

However, sometimes the IDT, plan, or authorized specialist needs more time. In this case, you will get a letter telling you that it could to take up to 3 more calendar days. The letter will explain why more time is needed.

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

If you want to ask for a fast coverage decision, you can do one of three things:

- Call your Care Manager;
- Call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week, or fax us at 1-855-264-3822 or
- Have your provider or your representative call Participant Services.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision *only* if you are asking for coverage for a service, item, or drug *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for a service, item, or drug you already got.)
2. You can get a fast coverage decision *only* if the standard 3 business day deadline could *seriously jeopardize your life, health, or ability to attain, maintain or regain maximum function*.

   ➔ **If your provider says that you need a fast coverage decision, you will automatically get one.**

   ➔ If you ask for a fast coverage decision without your provider's support, the IDT, plan, or authorized specialist will decide if you get a fast coverage decision.

   - If the IDT, plan, or authorized specialist decides that your health does not meet the requirements for a fast coverage decision, you will get a letter. The IDT, plan, or authorized specialist will also use the standard 3 business day deadline instead.
   - This letter will tell you that if your provider asks for the fast coverage decision, you will automatically get a fast coverage decision.
   - The letter will also tell how you can file a "fast grievance" about the decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for filing grievances, including fast grievances, see Section 10 on page 183.

If the coverage decision is Yes, when will I get the service, item, or drug?

If the coverage decision is **Yes**, that means you are approved to get the service, item, or drug. If possible, you will receive or start to receive the approved service, item, or drug within 3 business days from the date of our decision. If the service, item, or drug cannot reasonably be provided within 3 business days, your IDT will work with the provider to make sure you get the approved service, item, or drug as quickly as possible.

If the coverage decision is No, how will I find out?

If the answer is **No**, you will receive a letter explaining why. The plan or your IDT will also notify you by phone.

- If the IDT, plan, or authorized specialist says **No**, you have the right to ask us to change the decision. You can do this by making (or "filing") an appeal. Making an appeal means asking our plan to review the decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

Section 5.3: Level 1 Appeal for services, items, and drugs (but not Medicare Part D drugs)

What is an appeal?

An *appeal* is a formal way of asking us to review the coverage decision and change it if you think there was a mistake. If you or your provider disagree with the decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. ICAN is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to Aetna Better Health FIDA Plan. Our plan will review your coverage decision to see if it is correct. The reviewer will be someone at our plan who is not part of your Interdisciplinary Team (IDT) and was not involved in the original coverage decision. When we complete the review, we will give you our decision in writing. If you need a fast decision because of your health, we will also try to notify you by phone.

If we do not decide the Level 1 Appeal in your favor, we will automatically forward your appeal to the Integrated Administrative Hearing Office for a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your provider, or your representative must contact us. You can call us at **1-855-494-9945** (TTY: **711**) or you may appeal in writing. For additional details on how to reach us for appeals, see Chapter 2. You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a fast appeal, you should call us at **1-855-494-9945**. TTY users should call **711**.
- If you are asking for a standard appeal, make your appeal in writing or call us.
  - You can submit a request to the following address:

    Aetna Better Health FIDA Plan
    Attn: Grievance and Appeals Dept.
    55 West 125th Street, Suite 1300
    New York, NY 10027
  - You may also ask for an appeal by calling us at **1-855-494-9945**, 24 hours a day, 7 days a week. TTY users should call **711**.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because you were told that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.

→ Keep reading this section to learn about what deadline applies to your appeal.

Can someone else make the appeal for me?

Yes. Anyone can make the appeal for you, but only someone you designate in writing can represent you during your appeal. To make someone your representative, you must complete an "Appointment of Representative" form or write and sign a letter indicating who you want to be your representative. The form or letter gives the other person permission to act for you.

- To complete an "Appointment of Representative" form, call Participant Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **www.aetnabetterhealth.com/newyork**. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
- You can write a letter and either send it to us or have the person listed in the letter as your representative send it to us.

→ **NOTE:** Sometimes, a provider may appeal a plan decision about payment for your care. This is different from an appeal made on your behalf. You do not need to be involved in the provider's appeal.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter that you received informing you of the coverage decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

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

→ **NOTE:** If you appeal because you were told that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "*Will my benefits continue during Level 1 Appeals?*" on page 156 for more information.

Can I get a copy of my case file?

Yes. Call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week and ask for a copy of your case file. We will provide a copy of your case file at no cost to you.

Can my provider give you more information about my appeal?

Yes, you and your provider may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of services or items. Then, we check to see if all the rules were followed when the IDT, plan, or authorized specialist said **No** to your request. The reviewer will be someone who is not on your IDT and was not involved in making the original decision.

If we need more information, we may ask you or your provider for it.

When will I hear about a "standard" appeal decision?

If your appeal is about Medicaid prescription drugs, we must give you our answer within 7 calendar days from the date we received the appeal. For all other appeals, we must give you our answer within 30 calendar days from the date we received the appeal. We will give you our decision sooner if your health condition requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take additional time to make the decision, we will send you a letter that explains why we need more time.

- If you believe we should not take extra time, you can file a "fast grievance" about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, see Section 10 on page 183.
- If we do not give you an answer to your "standard" appeal within 7 calendar days (for Medicaid prescription drug appeals) or 30 calendar days (for all other appeals), or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens. For more information about the Level 2 Appeal process, go to Section 5.4 on page 156.

→ **If our answer is Yes** to part or all of what you asked for, we must approve the coverage within 7 calendar days after we get your Medicaid prescription drug appeal or 30 calendar days after we get your other type of appeal.

→ **If our answer is No** to part or all of what you asked for, we will send you a letter. The letter will tell you that we sent your case to the Integrated Administrative Hearing Office for a Level 2 Appeal. For more information about the Level 2 Appeal process, go to Section 5.4 on page 156.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you an answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra time to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra time, you can file a "fast grievance" about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, see Section 10 on page 183.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens. For more information about the Level 2 Appeal process, go to Section 5.4 on page 156.

→ **If our answer is Yes** to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

→ **If our answer is No** to part or all of what you asked for, we will send you a letter. The letter will tell you that we sent your case to the Integrated Administrative Hearing Office for a Level 2 Appeal. For more information about the Level 2 Appeal process, go to Section 5.4 on page 156.

Will my benefits continue during Level 1 Appeals?

If the IDT, plan, or authorized specialist decided to change or stop coverage for a service, item, or drug that you currently get, we will send you a notice before taking the proposed action.

If you disagree with the action, you can file a Level 1 Appeal. We will continue covering the service, item, or drug if you ask for a Level 1 Appeal **within 10 calendar days of the postmark date on our notice or by the intended effective date of the action**, whichever is later.

If you meet this deadline, you can keep getting the service, item, or drug with no changes while your appeal is pending. All other services, items, or drugs (that are not the subject of your appeal) will also continue with no changes.

Section 5.4: Level 2 Appeal for services, items, and drugs (but not Medicare Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will automatically send your case to Level 2 of the appeals process for review by the Integrated Administrative Hearing Office.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by the Integrated Administrative Hearing Office (IAHO). The IAHO is an independent organization that is not connected to Aetna Better Health FIDA Plan. The IAHO is part of the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA).

What will happen at the Level 2 Appeal?

We will automatically send any Level 1 denials (in whole or in part) to the IAHO for a Level 2 Appeal. We will notify you that your case was sent to Level 2 and that the IAHO will be in touch. The notice will also provide the contact information for the IAHO in the event that you do not hear from them to schedule your Level 2 Appeal hearing. You should receive a Notice of Administrative Hearing from the IAHO at least 10 calendar days before your hearing date. Your hearing will be conducted by a Hearing Officer in-person or on the phone. You may ask us for a copy of your case file by calling Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

Your Level 2 Appeal will either be a "standard" appeal or it will be a "fast" appeal. If you had a fast appeal at Level 1, you will automatically have a fast appeal at Level 2. Additionally, if the IAHO determines that you need a fast appeal, they will give you one. Otherwise, you will have a standard appeal.

- **Standard Level 2 Appeal:** If your standard appeal is about Medicaid prescription drugs, the IAHO must give you an answer within 7 calendar days of when it gets your appeal. For all other standard appeals, the IAHO must give you an answer within 62 calendar days from the date you asked for an appeal with our plan. The IAHO will give you a decision sooner if your health condition requires it.
- **Fast Level 2 Appeal:** The IAHO must give you an answer within 72 hours of when it gets your appeal.

Will my benefits continue during Level 2 Appeals?

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 156 for information about continuing your benefits during Level 1 Appeals.

All other services, items, and drugs (that are not the subject of your appeal) will also continue without any changes.

How will I find out about the decision?

When the IAHO makes a decision, it will send you a letter that explains its decision and provides information about your further appeal rights. If you qualified for a fast appeal, the IAHO will also tell you the decision by phone.

- If the IAHO says **Yes** to part or all of what you asked for, we must authorize the items or services immediately (within no more than 1 business day from the date of the decision).
- If the IAHO says **No** to part or all of what you asked for, it means that they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal." You can further appeal the IAHO's decision.

If the IAHO's decision is No for all or part of what I asked for, can I make another appeal?

If you disagree with the IAHO's decision, you may appeal that decision further to the Medicare Appeals Council (MAC) for a Level 3 Appeal. The IAHO's decision is not automatically forwarded to the MAC. Instead, you will have to request that appeal. Instructions on how to file an appeal with the MAC will be included in the IAHO's decision notice.

See Section 9 on page 182 for more information on additional levels of appeal.

Section 5.5: Payment problems

Aetna Better Health FIDA Plan has rules for getting services, items, and drugs. One of the rules is that the services, items, and drugs that you get must be covered by our plan. Another rule is that you must get your services, items, and drugs from providers that our plan works with. Chapter 3 explains the rules, including special rules for when you first join the plan. If you follow all of the rules, then we will pay for your services, items, and drugs.

If you are not sure if we will pay for a service, item, or drug, ask your Care Manager. Your Care Manager will be able to tell you if we will likely pay for the service, item, or drug, or if you need to ask us for a coverage decision.

If you choose to get a service, item, or drug that is not covered by our plan, or if you get a service, item, or drug from a provider that our plan does not work with, then we will not automatically pay for the service, item, or drug. In that case, you may have to pay for the service, item, or drug yourself. If you want to ask us for payment, start by reading Chapter 7: *Asking us to pay a bill you have gotten for covered services, items, or drugs*. Chapter 7 describes the situations in which you may need to ask us for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

What if I followed the rules for getting services, items, and drugs, but I got a bill from a provider?

We do not allow providers to bill you for covered services, items, and drugs. This is true even if we pay the provider less than the provider charges for a covered service, item, or drug. If a provider bills you for any charges that we did not pay, that is called "balance billing." You are never required to pay the balance of any bill.

If you get a bill for covered services, items, or drugs, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

Can I ask to be paid back for a service, item, or drug I paid for?

Remember, if you get a bill for a covered service, item, or drug, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services, items, and drugs.

If you are asking to be paid back, you are asking the plan or your Interdisciplinary Team (IDT) for a coverage decision. The plan or your IDT will decide if the service, item, or drug you paid for is covered, and will check to see if you followed all the rules for using your coverage.

- If the service, item, or drug you paid for is covered and you followed all the rules, we will reimburse you for the cost of the service, item, or drug within 60 calendar days after we get your request.

  Or, if you haven't paid for the service, item, or drug yet, we will send the payment directly to your provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.

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

What if the plan or your IDT says the plan will not pay?

If you do not agree with the plan or your IDT's decision, **you can make an appeal**. Follow the appeals process described in Section 5.3 on page 152. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.

- If you are asking us to pay you back for a service, item, or drug you already got and paid for yourself, you cannot ask for a fast appeal.

→ If we answer **No** to your appeal, we will automatically send your case to the Integrated Administrative Hearing Office (IAHO). We will notify you by letter if this happens.

  - If the IAHO reverses the 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 you asked for to you or to the provider within 60 calendar days.

  - If the IAHO says **No** to your appeal, it means they agree with the decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") You may appeal this decision to the Medicare Appeals Council, as described in Section 9 on page 182.

Section 6: Medicare Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your coverage as a Participant of our plan includes many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals**.

- The *List of Covered Drugs* (*Drug List*), includes some drugs with an asterisk (*). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an asterisk (*) symbol follow the process in **Section 5** on page 149.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) to make about your Part D drugs:

- You ask the plan or your IDT to make an exception such as:
  - Asking the plan or your IDT to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
  - Asking the plan or your IDT to waive a restriction on our coverage for a drug (such as limits on the amount of the drug you can get).
- You ask the plan or your IDT if a drug is covered for you (for example, when your drug is on our Drug List but we require you to get approval before we will cover it for you).
  - **NOTE:** If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining who to contact for a coverage decision.
- You ask the plan or your IDT to decide that the plan must pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> ***The legal term*** *for a coverage decision about your Part D drugs is* ***"coverage determination."***

If you disagree with a coverage decision made by the plan or your IDT, you can appeal. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you determine which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? **You can ask the plan or your IDT to make an exception.** (This is a type of coverage decision.) Start with **Section 6.2** on page 161. Also see Sections 6.3 and 6.4 on pages 162 and 163.	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? **You can ask the plan or your IDT for a coverage decision.** Skip ahead to **Section 6.4** on page 163.	Do you want to ask us to pay you back for a drug you have already got and paid for? **You can ask the plan or your IDT to have the plan pay you back.** (This is a type of coverage decision.) Skip ahead to **Section 6.4** on page 163.	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? **You can make an appeal.** (This means you are asking the plan to reconsider.) Skip ahead to **Section 6.5** on page 166.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs or is not covered in the way you would like, you can ask the plan or your Interdisciplinary Team (IDT) to make an "exception."

When you ask for an exception, your prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your prescriber can ask the plan or your IDT to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5).

- The extra rules and restrictions on coverage for certain drugs include:
  - » Being required to use the generic version of a drug instead of the brand name drug.
  - » Getting approval before the plan will cover the drug for you. (This is sometimes called "prior authorization.")
  - » Being required to try a different drug first before the plan will cover the drug you are asking for. (This is sometimes called "step therapy.")
  - » Quantity limits. For some drugs, the plan limits the amount of the drug you can have.

> ***The legal term*** *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your prescriber must tell us the medical reasons

Your prescriber must give the plan or your Interdisciplinary Team (IDT) a statement explaining the medical reasons for requesting an exception. The decision about the exception will be faster if you include this information from your prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, the plan or your IDT will generally *not* approve your request for an exception.

Aetna Better Health FIDA Plan or your IDT will say* Yes *or* No *to your request for an exception

- If the plan or your IDT says **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your provider continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If the plan or your IDT says **No** to your request for an exception, you can ask for a review of the decision by making an appeal. Section 6.5 on page 166 tells how to make an appeal.

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

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax your Care Manager or Participant Services to make your request. You, your representative, or prescriber can do this. You can call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. You can call your Care Manager at **1-855-494-9945** (TTY: **711**).
- You or your prescriber or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 4 on page 146 to find out how to give permission to someone else to act as your representative.

  → You do not need to give your prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask the plan to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for the cost of a drug you have paid for.
- If you are asking for an exception, provide the "supporting statement." Your provider must give the plan or your Interdisciplinary Team (IDT) the medical reasons for the drug exception. We call this the "supporting statement."

  Your prescriber can fax or mail the statement to us. Or your prescriber can speak with us on the phone, and then fax or mail a statement.

***At a glance:* How to ask for a coverage decision about a drug or payment**

Call, write, or fax your Care Manager or Participant Services. Or ask your representative or prescriber to ask for a coverage decision for you. You will get an answer on a standard coverage decision within 72 hours. You will get an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your prescriber.
- You or your prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

→ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

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

The "standard deadlines" will apply unless the plan or your IDT have agreed to use the "fast deadlines."

- A **standard coverage decision** means the plan or your IDT will give you an answer within 72 hours after your prescriber's statement is received.
- A **fast coverage decision** means the plan or your IDT will give you an answer within 24 hours after your prescriber's statement is received.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
  - » If your prescriber says that your health requires a "fast coverage decision," the plan or your IDT will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your prescriber's support), the plan or your IDT will decide whether you get a fast coverage decision.

    If the plan or your IDT decides that your medical condition does not meet the requirements for a fast coverage decision, the standard deadline will be used instead. You will get a letter telling you that. The letter will tell you how to file a grievance about the decision to give you a standard decision. You can file a "fast grievance" and get a response to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, see Section 10 on page 183.

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

Deadlines for a "fast coverage decision"

- If the plan or your IDT is using the fast deadlines, you will get an answer within 24 hours. This means within 24 hours after the plan or your IDT gets your request. Or, if you are asking for an exception, 24 hours after the plan or your IDT gets your prescriber's statement supporting your request. You will get an answer sooner if your health requires it.
- If the plan or your IDT does not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

- **If the answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after your request is received or your prescriber's supporting statement is received.
- **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If the plan or your IDT is using the standard deadlines, you will get an answer within 72 hours after your request is received. Or, if you are asking for an exception, after your prescriber's supporting statement is received. You will get an answer sooner if your health requires it.
- If the plan or your IDT does not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

- **If the answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours of your request or, if you are asking for an exception, your prescriber's supporting statement.
- **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- The plan or your IDT must give you an answer within 14 calendar days after your request is received.
- If the plan or your IDT does not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.

- **If the answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days after your request is received.
- **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice that tells you the decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your prescriber, or your representative can call us to ask for a fast appeal.

→ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term *for an appeal to the plan about a Part D drug coverage decision is a plan* ***"redetermination."***

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.
  - » If you wish, you and your prescriber may give us additional information to support your appeal.

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

- If you are appealing a decision the plan or your IDT made about a drug you have not yet received, you and your prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 on page 163.

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if all the rules were followed when the plan or your IDT said **No** to your request. We may contact you or your prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

> ***The legal term*** *for "fast appeal" is* ***"expedited redetermination."***

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➔ **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➔ **If our answer is Yes** to part or all of what you asked for:

  » If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

  » If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.
- You have a right to give the IRE other information to support your appeal.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your prescriber, or your representative can request the Level 2 Appeal.

→ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- The IRE is an independent organization that is hired by Medicare. It is not connected with the plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

The legal term *for an appeal to the IRE about a Part D drug is* ***"reconsideration."***

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - » If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - » If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

Section 7: Asking us to cover a longer hospital stay

When you are 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.

During your covered hospital stay, your doctor, Interdisciplinary Team (IDT), and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor, IDT, or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. There is a special, faster process for appealing hospital discharge decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section 5 on page 149. However, both options are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with the plan.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights*. If you do not get this notice, ask any hospital employee for it. If you need help, please call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* 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 are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

→ If you need help, please call Participant Services or Medicare at the numbers listed above.

Section 7.2: Quality Improvement Organization (QIO) Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. This section tells you how to ask for a Level 1 Appeal with the Quality Improvement Organization. The Quality Improvement Organization will do a Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

In New York, the Quality Improvement Organization is called Livanta. To make a Level 1 Appeal to change your discharge date, call Livanta at 1-866-815-5440 .

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-866-815-5440 and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

→ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page 174.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. You can also call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You may also call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a "**fast review**" of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> ***The legal term*** *for "fast review" is* ***"immediate review."***

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your provider, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your provider, the hospital, and we think it is right for you to be discharged on that date.

> ***The legal term*** *for this written explanation is called the* ***"Detailed Notice of Discharge."*** *You can get a sample by calling Participant Services at* ***1-855-494-9945*** *(TTY:* ***711****). 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.) Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html*

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Quality Improvement Organization (QIO) Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In New York, the Quality Improvement Organization is called Livanta. You can reach Livanta at 1-866-815-5440 .

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

***At a glance:* How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-855-408-8557 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss the Level 1 appeal deadline with the Quality Improvement Organization, you can still file an appeal directly with our plan. Follow the same process described in Section 5 on page 149, which is also summarized below.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can file an appeal with our plan. Ask us for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision as fast as your condition requires but no later than 72 hours after you ask for a "fast review."

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Participant Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

- **If we say No to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.

  » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

→ To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the Integrated Administrative Hearing Office. When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term*** *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

If we do not agree with you that your hospital discharge date should be changed, we will send the information for your Level 2 Appeal to the Integrated Administrative Hearing Office (IAHO) within 2 business days of the Level 1 decision being reached. If you think we are not meeting this deadline or other deadlines, you can file a grievance. Section 10 on page 183 tells how to file a grievance.

During the Level 2 Appeal, the IAHO reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IAHO does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The IAHO is not connected with our plan.
- A Hearing Officer from the IAHO will take a careful look at all of the information related to your appeal of your hospital discharge.

At a glance: **How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Integrated Administrative Hearing Office (IAHO).

- If the IAHO says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IAHO says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

  The letter you get from the IAHO will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by the Medicare Appeals Council (MAC). Section 9 of this chapter has more information about additional appeal levels.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

→ With any of these three types of care, you have the right to keep getting covered services for as long as your provider or Interdisciplinary Team (IDT) says you need it.

→ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your services*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. There is a special, faster process for appealing these types of coverage decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section 5 on page 149. However, both options are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with the plan.

Section 8.1: We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your services. This is called the *Notice of Medicare Non-Coverage*.

- The written notice tells you the date when we will stop covering your services.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting services.

When your coverage ends, we will stop paying for your services.

Section 8.2: Quality Improvement Organization (QIO) Level 1 Appeal to continue your care

If you think we are ending coverage of your services too soon, you can file an appeal. This section tells you how to ask for a Level 1 Appeal with the Quality Improvement Organization.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a grievance. 10 on page 183 tells you how to file a grievance.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. Or call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

During a Level 1 Appeal, the Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In New York, the Quality Improvement Organization is called Livanta. You can reach Livanta at 1-866-815-5440. Information about appealing to the Quality Improvement Organization is also in the *Notice of Medicare Non-Coverage*. This is the notice you got when you were told we would stop covering your care.

***At a glance:* How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization for your state at 1-855-408-8557 and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care*.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 on page 180.

> ***The legal term*** *for this written notice is* ***"Notice of Medicare Non-Coverage."*** *To get a sample copy, call Participant Services at* ***1-855-494-9945*** *(TTY:* ***711****), 24 hours a day, 7 days a week or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your provider, and review information that the plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term*** *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

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

Section 8.3: Quality Improvement Organization (QIO) Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the Level 1 Appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

In New York, the Quality Improvement Organization is called Livanta. You can reach Livanta at 1-866-815-5440. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

***At a glance:* How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization for your state at 1-866-815-5440 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss the Level 1 appeal deadline with the Quality Improvement Organization, you can still file an appeal directly with our plan. Follow the same process described in Section 5 on page 149, which is also summarized below.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can file an appeal with our plan. Ask us for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Participant Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision as quickly as your condition requires but not later than 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.
  - » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

→ To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the Integrated Administrative Hearing Office. When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term*** *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to continue your care for longer

If we do not agree with you that your services should continue, we will send the information for your Level 2 Appeal to the Integrated Administrative Hearing Office (IAHO) within 2 business days of the Level 1 decision being reached. If you think we are not meeting this deadline or other deadlines, you can file a grievance. Section 10 on page 183 tells how to file a grievance.

During the Level 2 Appeal, the IAHO reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IAHO does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The IAHO is not connected with our plan.
- A Hearing Officer from the IAHO will take a careful look at all of the information related to your appeal.
- If the IAHO says **Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- If the IAHO says **No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

At a glance: **How to make a Level 2 Alternate Appeal to require that the plan continue your care**

You do not have to do anything. The plan will automatically send your appeal to the Integrated Administrative Hearing Office (IAHO).

The letter you get from the IAHO will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal with the Medicare Appeals Council. Section 9 on page 182 has more information about additional appeal levels.

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for services, items, and drugs (not Medicare Part D drugs)

If you made a Level 1 Appeal and a Level 2 Appeal as described in Sections 5, 7, or 8, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Integrated Administrative Hearing Office (IAHO) will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is a review by the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800.

Section 9.2: Next steps for Medicare Part D drugs

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare Part D drugs as described in Section 6, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the drugs you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800.

Section 10: How to file a grievance

What kinds of problems should be grievances?

"Filing a grievance" is another way of saying "making a complaint." The grievance process is used for certain types of problems *only*, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the grievance process.

Grievances about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Grievances about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential*.

Grievances about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Aetna Better Health FIDA Plan staff treated you poorly.
- You think you are being pushed out of the plan.

Grievances about accessibility

- You cannot physically access the health care services and facilities in a provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Grievances about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by providers, pharmacists, or other health professionals or by Participant Services or other plan staff.

Grievances about cleanliness

- You think the clinic, hospital or provider's office is not clean.

***At a glance:* How to file a grievance**

You can file an internal grievance with our plan and/or an external grievance with an organization that is not connected to our plan.

To file an internal grievance, call Participant Services or send us a letter.

There are different organizations that handle external grievances. For more information, read Section 10.2 on page 186.

Grievances about language access

- Your provider does not provide you with an interpreter during your appointment.

Grievances about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Grievances about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain services.
- You believe we did not forward your case to the Integrated Administrative Hearing Office or Independent Review Entity on time.

Are there different types of grievances?

Yes. You may file an internal grievance and/or an external grievance. An internal grievance is filed with and reviewed by our plan. An external grievance is filed with and reviewed by an organization that is not affiliated with our plan. If you need help filing an internal and/or external grievance, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800.

Section 10.1: Internal grievances

To file an internal grievance, call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week. The grievance must be made **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Participant Services will tell you.
- You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing.

Most grievances are answered in 30 calendar days. If possible, we will answer you right away. If you call us with a grievance, 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.

- If you need a response faster because of your health, we will give you an answer within 48 hours after we get all necessary information (but no more than 7 calendar days from the receipt of your grievance).

- If you are filing a grievance because we denied your request for a "fast coverage decision" or a "fast appeal," we will respond to your grievance within 24 hours.
- If you are filing a grievance because we took extra time to make a coverage decision, we will respond to your grievance within 24 hours.

If we do not agree with some or all of your grievance, we will tell you and give you our reasons. We will respond whether we agree with the grievance or not. If you disagree with our decision, you can file an external grievance.

> ***The legal term*** *for "fast grievance" is* ***"expedited grievance."***

We answer most grievances within 30 calendar days. If possible, we will answer you right away. If you call us with a grievance, 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.

- If you need a response faster because of your health, we will give you an answer within 48 hours after we get all necessary information (but no more than 7 calendar days from the receipt of your grievance).
- If you are filing a grievance because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast grievance" and respond to your grievance within 24 hours.
- If you are filing a grievance because we took extra time to make a coverage decision, we will automatically give you a "fast grievance" and respond to your grievance within 24 hours.

If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days to answer your grievance. We will tell you in writing why we need more time.

If we do not agree with some or all of your grievance, we will tell you and give you our reasons. We will respond whether we agree with the grievance or not. If you disagree with our decision, you can file an external grievance.

Section 10.2: External grievances

You can tell Medicare about your grievance

You can send your grievance (complaint) to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

Your grievance will be sent to the Medicare and Medicaid team overseeing our plan and the FIDA Program.

You can tell the New York State Department of Health about your grievance

To file a grievance with the New York State Department of Health (NYSDOH), call the NYSDOH Helpline at 1-866-712-7197. Your grievance will be sent to the Medicare and Medicaid team overseeing our plan and the FIDA Program.

You can file a grievance with the Office for Civil Rights

You can file a grievance with the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can file a grievance about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at: 1-800-368-1019 (TTY users call 1-800-537-7697).

You may also have rights under the Americans with Disabilities Act. You can contact the Independent Consumer Advocacy Network (ICAN) for assistance. The phone number is 1-844-614-8800.

You can file a grievance with the Quality Improvement Organization

When your grievance is about *quality of care*, you also have two choices:

- If you prefer, you can make your grievance about the quality of care directly to the Quality Improvement Organization (*without* making the grievance to us).
- Or you can make your grievance to us **and** to the Quality Improvement Organization. If you make a grievance to this organization, we will work with them to resolve your grievance.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

In New York, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-866-815-5440.

Chapter 10: Ending your membership in our FIDA Plan

Table of Contents

Introduction

This chapter tells about ways you can end your participation in our FIDA Plan and access your Medicare and Medicaid coverage options after you leave Aetna Better Health FIDA Plan. You will still qualify for both Medicare and Medicaid benefits if you leave Aetna Better Health FIDA Plan.

A. When can you end your participation in our FIDA Plan?

You can end your participation in Aetna Better Health FIDA Plan at any time. Your participation will end 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 25, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month.

→ For information on Medicare options when you leave Aetna Better Health FIDA Plan, see the table on page 191.

→ For information about your Medicaid services when you leave Aetna Better Health FIDA Plan, see page 193.

These are ways you can get more information about when you can end your participation:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541.
- Call the Health Insurance Information, Counseling and Assistance Program (HIICAP). The phone number for HIICAP is 1-800-701-0501.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any issues you may have with your FIDA Plan. To contact ICAN, call 1-844-614-8800. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

B. How do you end your participation in our FIDA Plan?

If you decide to end your participation in Aetna Better Health FIDA Plan, call the Enrollment Broker or Medicare and tell them you want to leave Aetna Better Health FIDA Plan:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users 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 Aetna Better Health FIDA Plan is in the chart on page 191.

C. How do you join a different FIDA Plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different FIDA Plan.

To enroll in a different FIDA Plan:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541. Tell the Enrollment Broker you want to leave Aetna Better Health FIDA Plan and join a different FIDA Plan. If you are not sure which plan you want to join, the Enrollment Broker can tell you about other plans in your area; OR
- If you know the name of the FIDA Plan you want to join, send the Enrollment Broker an Enrollment Change Form. You can get the form at http://www.nymedicaidchoice.com or by calling the Enrollment Broker at 1-855-600-FIDA if you need them to mail you one. TTY users should call 1-888-329-1541.

Your coverage with Aetna Better Health FIDA Plan will end on the last day of the month that we get your request. Your coverage with the new FIDA Plan you selected will begin on the first day of the next month.

D. If you leave our FIDA Plan and you do not want a different FIDA Plan, how do you get your Medicare and Medicaid services from a single plan?

If you leave Aetna Better Health FIDA Plan and want to keep getting your Medicare and Medicaid services together from a single plan, you may be able to enroll in the Program of All-Inclusive Care for the Elderly (PACE) or the Medicaid Advantage Plus (MAP) Program.

To enroll in PACE or MAP:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541. Tell the Enrollment Broker you want to leave Aetna Better Health FIDA Plan and enroll in PACE or MAP. If you are not sure which PACE or MAP Plan you want to join, the Enrollment Broker can tell you about other plans in your area.

E. If you leave our FIDA Plan and you do not want a different FIDA, PACE, or MAP Plan, how do you get your Medicare and Medicaid services?

If you do not want to enroll in a different FIDA, PACE, or MAP Plan after you leave Aetna Better Health FIDA Plan, you will go back to getting your Medicare and Medicaid services separately as described below.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By enrolling in one of these options, you will automatically end your participation in Aetna Better Health FIDA Plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from Aetna Better Health FIDA Plan when your new plan's coverage begins.

2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from Aetna Better Health FIDA Plan when your Original Medicare coverage begins.
3. You can change to: **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 don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from Aetna Better Health FIDA Plan when your Original Medicare coverage begins.

How you will get Medicaid services

If you leave the FIDA Plan, you will still be able to get your Medicaid services.

- You will have the opportunity to switch to a Medicaid Managed Long-Term Care plan for your long-term services and supports and to get your Medicaid physical and behavioral health services through Medicaid Fee-for-Service. You can choose to completely stop getting long-term services and supports. However, it may take extra time to complete a safe discharge process.
  - » If you choose to completely stop getting long-term services and supports, we must ensure that you will be safe without the receipt of these services. To do this, we will complete a safe discharge process. This might take a few weeks from the date you tell us you want to leave long-term services and supports. During this time, you will be enrolled into the Medicaid Managed Long-Term Care plan operated by the same company as Aetna Better Health FIDA Plan. Your change request on your Medicare coverage will not be delayed and will take effect on the first day of the month after you ask for the change.
- If you were getting services through the Nursing Home Transition & Diversion 1915(c) waiver prior to enrolling in a FIDA Plan, you will have the opportunity to re-apply for the Nursing Home Transition & Diversion 1915(c) waiver. You will continue to get any existing Nursing Home Transition & Diversion services from Aetna Better Health FIDA Plan or enroll in a Medicaid Managed Long-Term Care plan to get your Medicaid services until your application for the Nursing Home Transition & Diversion 1915(c) waiver is approved. The Enrollment Broker (New York Medicaid Choice) can help you with your application.
- You will get a new Medicaid Participant ID Card, a new *Participant Handbook*, and a new *Provider and Pharmacy Directory*.

F. Until your participation ends, you will keep getting your medical services and drugs through our FIDA Plan

If you leave Aetna Better Health FIDA Plan, it may take time before your participation ends and your new Medicare and Medicaid coverage begins. See page 189 for more information. During this time, you will keep getting your services, items, and drugs through Aetna Better Health FIDA Plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your participation ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new coverage begins before you are discharged.

G. Your participation will end in certain situations (even if you haven't asked for it to end)

These are the cases when the FIDA Program rules require that your participation must end:

- If there is a break in your in Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid.
- If you permanently move out of our service area.
- If you are away from our service area for more than six consecutive months.
  - » If you move or take a long trip, you need to call Participant Services to find out if the place you are moving or traveling to is in Aetna Better Health FIDA Plan's service area.
- If you go to jail, prison, or a correctional facility for a criminal offense.
- If you lie about or withhold information about other insurance you have for health care or 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 Participant in our plan. The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a Participant on this basis. We must disenroll you if you don't meet this requirement.

In any of the above situations, the Enrollment Broker (New York Medicaid Choice) will send you a disenrollment notice and will be available to explain your other coverage options.

In addition, we can ask that the FIDA Program remove you from Aetna Better Health FIDA Plan for the following reasons:

- If you intentionally give us incorrect information when you are enrolling in Aetna Better Health FIDA 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 Participants of Aetna Better Health FIDA Plan even after we make and document our efforts to resolve any problems you may have.
- If you knowingly fail to complete and submit any necessary consent or release form allowing Aetna Better Health FIDA Plan and providers to access health care and service information that is necessary for us to deliver care to you.
- If you let someone else use your Participant ID Card to get medical care.
  - » If we end your participation because of this reason, Medicare may have your case investigated by the Inspector General.

In any of the above situations, we will notify you of our concern before we ask for FIDA Program approval to have you disenrolled from Aetna Better Health FIDA Plan. We will do this so that you have the opportunity to resolve the problems first. If the problems aren't resolved, we will notify you again once we have submitted the request. If the FIDA Program approves our request, you will get a disenrollment notice. The Enrollment Broker will be available to explain your other coverage options.

H. We *cannot* ask that you be disenrolled from our FIDA Plan for any reason related to your health

If you feel that we are asking that you be disenrolled from Aetna Better Health FIDA Plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You should also call Medicaid at 1-800-541-2831. You may have the right to ask for a fair hearing if the FIDA Program ends your participation in our FIDA Plan.

I. You may have the right to ask for a fair hearing if the FIDA Program ends your participation in our FIDA Plan

If the FIDA Program ends your participation in Aetna Better Health FIDA Plan, the FIDA Program must tell you its reasons in writing. It must also explain how you can ask for a fair hearing about the decision to end your participation.

J. You have the right to file a grievance with Aetna Better Health FIDA Plan if we ask the FIDA Program to end your participation in our FIDA Plan

If we ask the FIDA Program to end your participation in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance about our request to end your participation. You can see Chapter 9 for information about how to file a grievance.

→ **Note:** You can use the grievance process to express your dissatisfaction with our request to end your participation. However, if you want to ask that the decision be changed, you must file a fair hearing as described in Section I just above.

K. Where can you get more information about ending your participation in our FIDA Plan?

If you have questions or would like more information on when we can end your participation, you can call Participant Services at **1-855-494-9945**, 24 hours a day, 7 days a week. TTY users call **711**.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any issues you may have with your FIDA Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Chapter 11: Legal notices

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A. Notice about laws

Many laws apply to this *Participant Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your age, claims experience, color, creed, ethnicity, evidence of insurability, gender, genetic information, geographic location, health status, medical history, mental or physical disability, national origin, race, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

C. Notice about Aetna Better Health FIDA Plan as a second payer

Sometimes someone else has to pay first for the services, items, and drugs that we provide. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

Aetna Better Health FIDA Plan has the right and responsibility to collect payment for covered services, items, and drugs when someone else has to pay first.

Aetna Better Health FIDA Plan's Right of Subrogation

Subrogation is the process by which Aetna Better Health FIDA Plan gets back some or all of the costs of your health care from another insurer. Examples of other insurers include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' Compensation

If an insurer other than Aetna Better Health FIDA Plan should pay for services, items, or drugs related to an illness or injury, Aetna Better Health FIDA Plan has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by Aetna Better Health FIDA Plan will be secondary when another plan, including another insurance plan, provides you with coverage for FIDA-covered services, items, or drugs.

Aetna Better Health FIDA Plan's Right of Reimbursement

If you get money from a lawsuit or settlement for an illness or injury, Aetna Better Health FIDA Plan has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

Your Responsibilities

As a Participant of Aetna Better Health FIDA Plan, you agree to:

- Let us know of any events that may affect Aetna Better Health FIDA Plan's rights of Subrogation or Reimbursement.
- Cooperate with Aetna Better Health FIDA Plan when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
- Sign documents to help Aetna Better Health FIDA Plan with its rights to Subrogation and Reimbursement.
- Authorize Aetna Better Health FIDA Plan to investigate, request and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.

If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

D. Patient confidentiality and notice about privacy practices

We will ensure that all information, records, data, and data elements related to you, used by our organization, employees, subcontractors, and business associates, shall be protected from unauthorized disclosure pursuant to 42 CFR Part 431, Subpart F; 45 CFR Part 160; and 45 CFR Part 164, Subparts A and E.

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, call Participant Services at **1-855-494-9945** (TTY: **711**), 24 hours a day, 7 days a week.

E. Notice of action

We must use a coverage determination notice to notify you of a denial, termination, and delay or modification in benefits. If you disagree with our decision, you can file an appeal with our plan. You will not have to pay for any of these proceedings. For more information about appeals, see Chapter 9.

Chapter 12: Definitions of important words

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, walking, or brushing the teeth.

Aid paid pending: You can continue getting your services or items that are the subject of your appeal while you are waiting for a decision on a Level 1, 2, or 3 Appeal. This continued coverage is called "aid paid pending" or "continuing benefits." All other services and items automatically continue at approved levels during your appeal.

Appeal: A way for you to challenge a coverage decision if you think it is wrong. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person when only Aetna Better Health FIDA Plan should be billed. We do not allow providers to "balance bill" you. Because Aetna Better Health FIDA Plan pays the entire cost for your services, you should not get any bills from providers. Call Participant Services if you get any bills that you do not understand.

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 active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Manager: One main person who works with you, with the FIDA Plan, with your care providers, and with your Interdisciplinary Team (IDT) to make sure you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid. Chapter 2 explains how to contact CMS.

Comprehensive assessment: A review of your medical history, your needs and preferences, and your current conditions. It is used by you and your Interdisciplinary Team (IDT) to develop your Person-Centered Service Plan (PCSP). The term refers both to the initial comprehensive assessment you will have when you first join Aetna Better Health FIDA Plan or within six months of your last assessment if you joined Aetna Better Health FIDA Plan from Aetna Better Health of New York MLTC and the subsequent comprehensive re-assessments you will have at least every six months but more frequently if necessary due to changes in your needs. The comprehensive assessment and reassessments will be completed by a Registered Nurse in your home, which may include the hospital, nursing facility, or any other place you live at the time the assessment occurs.

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.

Continuing benefits: See "aid paid pending."

Coverage decision: A decision made by your IDT, Aetna Better Health FIDA Plan, or another authorized provider about whether Aetna Better Health FIDA Plan will cover a service for you. This includes decisions about covered services, items, and drugs. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and other drugs covered by Aetna Better Health FIDA Plan.

Covered services and items: 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 covered by Aetna Better Health FIDA Plan. Covered services and items are individually listed in Chapter 4.

Disenrollment: The process of ending your participation in Aetna Better Health FIDA Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tier: A group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). Every drug on the List of Covered Drugs is in one of 3 tiers.

Emergency: A medical emergency is when you, or any other person with 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 function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. The plan covers emergency care from out-of-network providers.

Enrollment Broker: The independent entity (New York Medicaid Choice) that handles FIDA Plan enrollments and disenrollments for the State of New York.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Explanation of Benefits (EOB): A summary of the drugs you got during a certain month. It also shows the total payments made by Aetna Better Health FIDA Plan and Medicare for you since January 1.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in New York State court and show that a decision we made about your Medicaid or FIDA Program eligibility is wrong.

Fully Integrated Duals Advantage (FIDA) Plan: A managed care organization under contract with Medicare and Medicaid to provide eligible individuals with all services available through both programs as well as new services. The plan is 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. They all work together to provide the care you need.

Fully Integrated Duals Advantage (FIDA) Program: A demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the State and federal government are testing new ways to improve how you get your Medicare and Medicaid health care services.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: 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 your care, our network providers, or our network pharmacies.

Health Insurance Information, Counseling and Assistance Program (HIICAP): HIICAP is the State Health Insurance Assistance Program for New York. HIICAP gives free health insurance counseling to people with Medicare. HIICAP is not connected with any insurance company, managed care plan, or FIDA Plan.

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 a terminal illness and is expected to have six months or less to live. 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. Aetna Better Health FIDA Plan must give you a list of hospice providers in your geographic area.

Independent Consumer Advocacy Network (ICAN): An office that helps you if you are having problems with Aetna Better Health FIDA Plan. ICAN's services are free. See Chapter 2 for information about how to contact ICAN.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated Administrative Hearing: A meeting before the Integrated Administrative Hearing Office during which you can explain why you think Aetna Better Health FIDA Plan or your Interdisciplinary Team (IDT) made the wrong decision.

Integrated Administrative Hearing Office (IAHO): A unit within the New York State Office of Temporary and Disability Assistance that conducts many of the Level 2 Appeals as described in Chapter 9.

Interdisciplinary Team (IDT): Your IDT will include your Primary Care Provider (PCP), Care Manager, and your choice of other health professionals (including your Primary Care Provider (PCP) who are there to help you get the care you need. Your IDT will also help you make a Person-Centered Service Plan (PCSP) and coverage decisions.

List of Covered Drugs (Drug List): A list of prescription drugs covered by Aetna Better Health FIDA Plan. Aetna Better Health FIDA Plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that 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. LTSS are sometimes also referred to as long-term care, long-term supports and services, or home and community-based services.

Managed Long-Term Care Program (MLTCP): The Managed Long-Term Care Program is the Medicaid program through which eligible individuals can get community or facility-based long-term services and supports (LTSS) through a managed care plan under contract to provide these and other Medicaid services.

Medicaid (or Medical Assistance): A program run by the federal government and the State that helps people with limited incomes and resources pay for health care, long-term services and supports, and medical costs. It covers extra services and 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. See Chapter 2 for information about how to contact Medicaid in your state.

Medicaid Advantage Plus (MAP) Program: A Medicare and Medicaid managed care plan program that is available to eligible individuals as an alternative to the FIDA Program. Please see Chapter 10 for more information about selecting the MAP.

Medically necessary: Those services and items necessary to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. Aetna Better Health FIDA Plan will provide coverage in accordance with the more favorable of the current Medicare and New York State Department of Health (NYSDOH) coverage rules, as outlined in NYSDOH and federal rules and coverage guidelines.

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.

Medicare Appeals Council: The entity that conducts Level 3 Appeals, as described in Chapter 9.

Medicare-covered services and items: Services and items covered by Medicare Part A and Part B. All Medicare health plans, including Aetna Better Health FIDA Plan, must cover all of the services and items that are covered by Medicare Part A and Part B.

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 (like lab tests, surgeries, and doctor visits) and supplies (like 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 that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Aetna Better Health FIDA Plan includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for Aetna Better Health FIDA Plan Participants. We call them "network pharmacies" because they have agreed to work with Aetna Better Health FIDA Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, 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 the health plan and accept our payment and not charge our Participants an extra amount. While you are a Participant of Aetna Better Health FIDA Plan, you must use network providers to get covered services and items, unless under certain conditions such as in cases of an emergency or urgently needed care. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Organization determination: Aetna Better Health FIDA Plan has made an organization determination when it, or one of its providers, makes a decision about whether services and items are covered or how much you have to pay for covered services and items. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the federal government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers in amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in Aetna Better Health FIDA Plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with Aetna Better Health FIDA Plan to coordinate or provide covered drugs to Participants of Aetna Better Health FIDA Plan. Most drugs you get from out-of-network pharmacies are not covered by Aetna Better Health FIDA Plan 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 Aetna Better Health FIDA Plan and is not under contract to provide covered services and items to Participants of Aetna Better Health FIDA Plan. Chapter 3 explains out-of-network providers or facilities.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

Partial/MLTC Plan: A Medicaid managed care plan program that is available to eligible individuals as an alternative to the FIDA Program for Medicaid long-term services and supports (LTSS).

Participant (Participant of our plan, or plan Participants): A person with Medicare and Medicaid who qualifies to get covered services and items through the FIDA Program, who has enrolled in Aetna Better Health FIDA Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the State.

***Participant Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a Participant of Aetna Better Health FIDA Plan.

Participant Services: A department within Aetna Better Health FIDA Plan responsible for answering your questions about your participation, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Participant Services.

Person-Centered Service Plan (PCSP): A plan for what services and items you will get, how you will get them, and your goals of care. Your PCSP is developed by your Interdisciplinary Team (IDT) with your input.

Primary Care Provider (PCP): Your main doctor or other provider who is responsible for providing many of your preventive and primary care services and items. Your PCP will be a part of your Interdisciplinary Team (IDT), if you so choose. If on your IDT, your PCP will participate in developing your Person-Centered Service Plan (PCSP), making coverage determinations about services and items requested by or for you, and approving authorizations for services and items that will be part of your PCSP. Your PCP may be a primary care physician, a nurse practitioner, or a physician assistant. For more information, see Chapter 3.

Prior authorization: Approval needed before you can get certain covered services, items, or drugs. Some services, items, and drugs are covered only if Aetna Better Health FIDA Plan, your IDT, or another specific provider authorizes them for you. Covered services and items that need prior authorization are marked in the Covered Items and Services Chart in Chapter 4. Some drugs are covered only if you get prior authorization from Aetna Better Health FIDA Plan or the IDT. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Program of All-Inclusive Care for the Elderly (PACE): A Medicare and Medicaid managed care plan program that is available to eligible individuals as an alternative to the FIDA Program. Please see Chapter 10 for more information about selecting PACE.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to Participants. See Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Self-directed care: A program that gives you the flexibility to choose and manage your caregivers. You (or your designee) are responsible for recruiting, hiring, training, supervising, and terminating caregivers. For more information, see Chapters 3 and 4.

Service area: A geographic area where a health plan accepts Participants. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Aetna Better Health FIDA Plan may request FIDA Program permission to drop you from the FIDA Plan if you move out of the FIDA Plan's service area. For more information about the FIDA Plan's service area, see Chapter 1.

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 Medicaid agency: The New York State Medicaid Agency is the New York State Department of Health (NYSDOH), Office of Health Insurance Programs (OHIP).

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Urgently needed care: Care you get for a sudden 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 network providers are unavailable or you cannot get to them.

Notes

AETNA BETTER HEALTH FIDA PLAN
55 W 125th St, Suite 1300
New York, NY 10027

Aetna, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Aetna Medicaid Civil Rights Coordinator

If you believe that Aetna, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Aetna Medicaid Civil Rights Coordinator, 4500 Cotton Center Blvd., Phoenix, AZ 85040, 1-888-234-7358, TTY 711, 860-900-7667, MedicaidCRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Aetna Medicaid Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-385-4104** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-385-4104** (TTY: **711**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-385-4104** (TTY: **711**)。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-385-4104** (телетайп: **711**).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-385-4104** (TTY: **711**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-385-4104** (TTY: **711**) 번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-385-4104** (TTY: **711**).

Yiddish: אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: **711**) **1-800-385-4104**

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারনে, তাহলে নিঃখরচায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে। ফোন করুন **1-800-385-4104** (TTY: **711**)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-385-4104** (TTY: **711**).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-385-4104** (رقم هاتف الصم والبكم: **711**).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-385-4104** (ATS: **711**).

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-385-4104** (TTY: **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-385-4104** (TTY: **711**).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-385-4104** (TTY: **711**).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-800-385-4104** (TTY: **711**).

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