Summary of Benefits 2021

Aetna Medicare Advantra Cares (HMO D-SNP)
H3959 - 035
January 1, 2021 - December 31, 2021

H3959-035

Aetna Medicare Advantra Cares (HMO D-SNP) is a Dual Eligible Special Needs Plan (D-SNP) for Medicare beneficiaries who are also eligible for Medicaid. This is a Medicare Advantage plan that covers prescription drugs.

The amount that a member pays for premiums, deductibles, copayments, and/or coinsurance may vary based on the level of Medicaid eligibility and "Extra Help" a member receives. To enroll in this plan, you must be enrolled in one of the following Medicare Savings Programs.

- **Qualified Medicare Beneficiary (QMB):** Medicaid covers your Medicare cost-shares, including deductibles, premiums, copayments, and coinsurance for medical services. You will only pay copayments for Part D prescription drugs.
- **Qualified Medicare Beneficiary Plus (QMB Plus):** Medicaid covers your Medicare cost-shares, including deductibles, premiums, copayments, and coinsurance for medical services. You are also eligible for full Medicaid benefits from your state Medicaid program. You will only pay copayments for Part D prescription drugs.
- **Specified Low-Income Beneficiary (SLMB):** Medicaid covers your Medicare Part B premium only.
- **Specified Low-Income Beneficiary Plus (SLMB Plus):** Medicaid covers your Medicare Part B premium. You are also eligible for full Medicaid benefits from your state Medicaid program.
- **Full Benefit Dual Eligible (FBDE):** You are eligible for full Medicaid benefits from your state Medicaid program. In addition, Medicaid may cover some of your Medicare cost-sharing for medical services, depending on your state's Medicaid program.
- **Qualified Disabled and Working Individual (QDWI):** Medicaid covers your Medicare Part A premium only.
- **Qualifying Individual (QI):** Medicaid covers your Medicare Part B premium only.

To join Aetna Medicare Advantra Cares (HMO D-SNP), you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area. You must also be enrolled in one of the Medicare Savings Programs listed above.

Service area: Pennsylvania: Bucks, Chester, Delaware, Montgomery, Philadelphia.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service or every limitation and exclusion. The plan's Evidence of Coverage (EOC) provides a complete list of services we cover. The EOC is available at **www.aetnamedicare.com** or you may call us to request a copy.

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Call us or go online for more information.

1-833-859-6031 (TTY: 711)
October 1 to March 31: 7 days a week from 8 a.m. - 8 p.m. local time
April 1 to September 30: Monday through Friday from 8 a.m. - 8 p.m. local time

www.aetnamedicare.com

Compare our plan to Medicare

To learn more about the coverage and costs of Original Medicare, look in your "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

What you should know

- **Primary Care Physician (PCP):** A PCP is important for receiving care and this plan requires you to select a PCP. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can always change the PCP by calling us.
- **Referrals:** Aetna Medicare Advantra Cares (HMO D-SNP) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.
- **Prior authorizations:** Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Remember to show both your Aetna Medicare Advantra Cares (HMO D-SNP) ID card and your Medicaid card when getting care.

You can find more details on each benefit listed below in the Evidence of Coverage (EOC).

Plan costs and information	
Monthly plan premium	$0 up to $30.90 depending on your level of Extra Help. You must keep paying your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program.
Plan deductible	$0 or $140
	This is the amount you pay for certain services before Aetna Medicare Advantra Cares (HMO D-SNP) begins to pay. The plan deductible applies only to certain services.

Plan costs and information	
Maximum out-of-pocket amount (does not include prescription drugs)	$7,550
	This is the most you pay for copays, coinsurance, and other costs for medical services for the year. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drugs don't count toward the maximum out-of-pocket.

Primary benefits	Your costs
Hospital coverage*	
Inpatient hospital coverage	$0 per stay or $1,200 per stay after your plan deductible
Outpatient hospital observation services	$0 or 20% after your plan deductible
Outpatient hospital services	$0 or 20% after your plan deductible
Ambulatory surgical center	$0 or 20% after your plan deductible
Doctor visits	
Primary care physician (PCP)	$0 or 0% after your plan deductible
Specialists	$0 or 0% after your plan deductible

Primary benefits	Your costs
Preventive care	$0 Preventive care includes: • Abdominal aortic aneurysm screenings • Alcohol misuse screenings & counseling • Bone mass measurements • Breast cancer screening: mammogram • Cardiovascular disease screenings • Cardiovascular behavior therapy • Cervical & vaginal cancer screenings • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screenings • Diabetes screenings • HBV infection screening • Hepatitis C screening tests • HIV screenings • Lung cancer screenings • Nutrition therapy services • Obesity behavior therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings & counseling • Tobacco use cessation counseling • Vaccines: flu, hepatitis B, pneumococcal • Welcome to Medicare preventive visit • Yearly wellness visit
Emergency & urgent care	
Emergency care in the United States	$0 or 20% (up to $90)
Urgently needed care in the United States	$0 or 20% (up to $65)
Emergency & urgently needed care worldwide	Emergency care: $0 or 20% Urgently needed care: $0 or 20% Ambulance: $0 or 20% $50,000 maximum benefit for worldwide emergency and urgent care combined.

Primary benefits	Your costs
Diagnostic Testing*	
Diagnostic radiology (e.g. MRI & CT scans)	$0 or 0% - 20% after your plan deductible
	Lower cost sharing: for services provided by your primary care physician in their office Higher cost sharing: for services performed by a provider other than your primary care physician
Lab services	$0 or 0% after your plan deductible
Diagnostic tests & procedures	$0 or 20% after your plan deductible
Outpatient x-rays	$0 or 20% after your plan deductible
Hearing, dental, and vision	
Diagnostic hearing exam	$0 or 20% after your plan deductible
Routine hearing exam	$0
	We cover one exam every year. All appointments must be scheduled through NationsHearing.
Hearing aids	Our plan pays up to a maximum amount of $1,250 per ear, every year. You are responsible for any costs over this amount.
	NationsHearing will manage your hearing aid benefits. All hearing aids must be purchased through NationsHearing.
Dental services	Our plan pays up to $4,000 every year for covered services. Cosmetic procedures are not covered. You are responsible for any costs over this amount.
	Aetna Dental will manage your dental benefits. If you choose a provider outside of the network, services will not be covered.
Glaucoma screening	$0 or 0% after your plan deductible
Diagnostic eye exams (including diabetic eye exams)	$0 or 20% after your plan deductible
Routine eye exam	$0
	We cover one exam every year.

Primary benefits	Your costs
Contacts and eyeglasses	Our plan pays up to a maximum amount of $500 every year. You are responsible for any costs over this amount. EyeMed will manage your eyewear benefits. If you choose a provider outside of the network, services will not be covered.
Mental health services*	
Inpatient psychiatric stay	$0 or $1,200 per stay after your plan deductible
Outpatient mental health therapy (individual)	$0 or 40% after your plan deductible
Outpatient psychiatric therapy (individual)	$0 or 40% after your plan deductible
Skilled nursing*	
Skilled nursing facility (SNF)	$0 per stay or $0 per day, days 1-20; $184 per day, days 21-100 after your plan deductible
	Our plan covers up to 100 days.
Therapy*	
Physical and speech therapy	$0 or 20% after your plan deductible
Ambulance & routine transportation	
Ground ambulance (one-way trip)	$0 or 20% after your plan deductible
	Cost sharing is waived if you are admitted to the hospital.
Air ambulance* (one-way trip)	$0 or 20% after your plan deductible
	Cost sharing is waived if you are admitted to the hospital.
Routine transportation (non-emergency)	$0
	Our plan covers 40 one-way trips every year to approved locations. Access2Care will manage your transportation benefit.

Primary benefits	Your costs
Medicare Part B drugs*	
Chemotherapy drugs	$0 or 20% after your plan deductible
Other Part B drugs	$0 or 20% after your plan deductible

* Prior authorization may be required for these benefits. See the EOC for details.

Prescription drug coverage if you qualify for Extra Help (The amount you pay depends on the amount of Extra Help you get and the pharmacy you choose)	
Formulary name	B2 (You can use this when referencing our list of covered drugs)
Deductible You pay the full cost of drugs until you reach your deductible.	
The deductible applies to Tiers 3, 4 and 5.	$0 or $92.00
Prescription drug costs You pay the costs below for a 30, 60, or 90 day supply of drugs. (For specialty drugs, you are limited to a 30 day supply.)	
Drugs on Tiers 1 and 2	$0
Other drugs:	(costs below are based on your LIS level)
Generic drugs	$0, $1.30, $3.70, or 15%
All other drugs	$0, $4.00, $9.20, or 15%

Prescription drug coverage if you <u>do not</u> qualify for Extra Help (Your costs may be lower if you qualify for Extra Help)	
Formulary name	B2 (You can use this when referencing our list of covered drugs)
Stage 1: Deductible You pay the full cost of drugs until you reach your deductible.	
The deductible applies to Tiers 3, 4 and 5	$130

Prescription drug coverage if you do not qualify for Extra Help (Your costs may be lower if you qualify for Extra Help)		
Stage 2: Initial coverage You pay the costs below until your total drug costs reach $4,130. You pay the copay listed below or the cost of the drug, whichever is lower. These cost shares may also apply to Home Infusion drugs when obtained through your Part D benefit. For Long Term Care, you'll get a 31 day supply.		
	30-day supply through Retail or Mail	**90-day supply through Retail or Mail**
	Standard	**Standard**
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	$47	$141
Tier 4: Non-Preferred Drug	$100	$300
Tier 5: Specialty	30%	N/A
Stage 3: Coverage gap The coverage gap lasts until your out-of-pocket drug costs reach $6,550.		
Brand Name Drugs	25% of the plan's cost	
Generic Drugs	25% of the plan's cost	
Stage 4: Catastrophic coverage You pay a small cost share for each drug.		
Generic Drugs	You pay the greater of 5% of the cost of the drug or $3.70	
Brand Name Drugs	You pay the greater of 5% of the cost of the drug or $9.20	

Other benefits	**Your costs**
Equipment, prosthetics, and supplies*	
Diabetic supplies	0%
	We exclusively cover blood glucose monitors and diabetic test strips manufactured by OneTouch / LifeScan.
Durable medical equipment (e.g. wheelchair, oxygen)	$0 or 20% after your plan deductible

Other benefits	Your costs
Prosthetics (e.g. braces, artificial limbs)	$0 or 20% after your plan deductible
Substance abuse	
Outpatient substance abuse (Individual therapy)*	$0 or 40% after your plan deductible

* Prior authorization may be required for these benefits. See the EOC for details.

Additional benefits provided by Aetna Medicare Advantra Cares (HMO D-SNP)	Benefit information and your costs
Fall prevention	Our plan pays up to a maximum amount of $150 every year for certain clinically appropriate home and bathroom safety devices that can improve your ability to move around your home. An Aetna Care Manager will determine your eligibility for this benefit. CVS® will manage your fall prevention benefit.
Fitness	Standard membership at participating SilverSneakers® facilities and access to online wellness related tools, planners, newsletters, and classes, at no extra cost. You can get an at-home fitness kit if you don't live near a participating club or prefer to exercise at home.
Routine foot care	0%
	We cover one visit every three months.
Help during a COVID-19 Public Health Emergency	You'll always pay $0 for COVID-19 testing, even if the COVID-19 Public Health Emergency ends. Additionally, during a COVID-19 Public Health Emergency we offer these extra services: • Mental health & psychiatric telehealth services with network providers • You may be eligible for a package of supplies, if you've tested positive, to help prevent the spread of COVID-19 and assist with recovery
Meals	When you get home after an inpatient hospital or skilled nursing stay, we cover up to 14 home delivered meals over a 7 day period. You will be contacted to schedule delivery if eligible and meals will be provided through GA Foods®.

Additional benefits provided by Aetna Medicare Advantra Cares (HMO D-SNP)	Benefit information and your costs
Nursing hotline	Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.
Over-the-counter items (OTC)	Get over-the-counter health & wellness products by mail. Our plan pays up to a maximum amount of $255 every three months.
	CVS will manage your OTC benefit. See the OTC catalog for a list of eligible items. You can find the catalog at www.cvs.com/otchs/myorder.
Personal emergency response system	Members are eligible to receive a medical alert system that gives 24/7 access to help if you fall or have another emergency. Lifestation will manage your Personal Emergency Response System benefit.
Resources For Living®	Resources For Living® helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities, and more.
Telehealth	You can receive primary care and urgent care services via a virtual visit for the same cost as an in-person visit. Depending on your location, you also have 24/7 access to MinuteClinic® Video Visits. Find out if these visits are available in your area at www.cvs.com/minuteclinic/virtual-care/video-visit.

Summary of Medicaid-Covered Benefits

People who qualify for Medicare and Medicaid (also called "Medical Assistance") are known as dual eligibles. As a dual eligible, you are eligible for benefits under both the Federal Medicare program and the PA Medicaid program.

The benefits described in the Covered Medical and Hospital Benefits section (earlier in this document) are covered by Aetna Medicare Advantra Cares (HMO D-SNP). The services listed below are offered under the Pennsylvania State Medicaid Plan for recipients 21 years of age and older who are eligible for Medical Assistance benefits and Medicare as Qualified Medicare Beneficiaries (QMBs) and Special Low Income Medicare Beneficiaries (SLMBs). What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility or benefits call 1-800-692-7462.

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package**	
Services	**Adult Benefit Package**
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Services and Medical and Surgical Services provided by a Dentist	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	No limits
Optometrist Services	2 visits (exams) per calendar year
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, and CTs)	No limits

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package**	
Services	**Adult Benefit Package**
Dental Care Services	Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime. Denture relines - either full or partial, limited to 1 arch every 2 calendar years. Oral exams - 1 per 180 days Dental prophylaxis - 1 per 180 days Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years. Crowns, Periodontics and Endodontics only via approved benefit limit exception.
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
Category 2: Emergency Services	
Emergency Room	No limits

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package**	
Services	**Adult Benefit Package**
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug and Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity-Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug and Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management-other than Behavioral Health	Limited to individuals identified in the target group (No limits).
Targeted Case Management-Behavioral Health Only	Limited to individuals with Serious Mental Illness (SMI) only (No limits).
Category 6: Prescription Drugs	
Prescription Drugs	No limits

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package**	
Services	**Adult Benefit Package**
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	
Skilled Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services.	Unlimited for first 28 days; limited to 15 days every month thereafter.
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits).
Durable Medical Equipment	No limits
Prosthetics and Orthotics	Orthopedic Shoes and Hearing Aids are not covered. Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications. Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or split. Coverage for low vision aids and eye prosthesis is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.
Eyeglass Lenses	Limited to individuals diagnosed with Aphakia - 4 lenses per calendar year.
Eyeglass Frames	Limited to individuals diagnosed with Aphakia - 2 frames per calendar year. Deluxe frames not included.

Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package**	
Services	**Adult Benefit Package**
Contact Lenses	Limited to individuals diagnosed with Aphakia - 4 lenses per calendar year.
Medical Supplies	No limits
Therapy (physical, occupational, speech) - Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Therapy (physical, occupational, speech) - Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventive /Wellness Services and Chronic Care	
Tobacco Cessation***	70, 15-minute visits per calendar year
All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule. **Children's benefit plan will include all medically necessary services without limitation. ***Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force. For a full listing of preventative services beyond tobacco cessation, please contact your MCO.	

Home and Community-Based Services (HCBS)	
Services	**Limits**
Adult Daily Living Services Assistive Technology Behavioral Therapy Benefits Counseling Career Assessment	Under Community Integration Each distinct goal may not be more than twenty-six (26) weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved.

Home and Community-Based Services (HCBS)	
Services	**Limits**
Cognitive Rehabilitation Therapy Community Integration Community Transition Services Counseling Employment Skills Development	However, the Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks. Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office.
Home Adaptations Home Delivered Meals Home Health Aide Home Health- Nursing Home Health - Occupational Therapy	Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceeds 50 hours a week must obtain prior approval. Under Specialized Medical Equipment and Supplies non-covered items include:
Home Health - Physical Therapy Home Health - Speech and Language Therapy Job Coaching Job Finding	All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream) Items covered under third party payer liability Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability
Non-Medical Transportation Nutritional Counseling Participant-Directed Community Supports Participant- Directed Goods and Services Personal Assistance Services	Food, food supplements, food substitutes (including formulas), and thickening agents Eyeglasses, frames and lenses Dentures Any item labeled as experimental that has been denied by Medicare and/or Medicaid

Home and Community-Based Services (HCBS)	
Services	**Limits**
Personal Emergency Response System (PERS) Pest Eradication Residential Habilitation Respite Service Coordination	Recreational or exercise equipment and adaptive devices for such
Specialized Medical Equipment and Supplies Structured Day Habilitation TeleCare Vehicle Modification	

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-833-859-6031 (TTY: 711)**. From October 1 to March 31, you can call us 7 days a week from 8 a.m. - 8 p.m. local time. From April 1 to September 30, we're here Monday through Friday from 8 a.m. - 8 p.m. local time.

Understanding the benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially those services for which you routinely see a doctor. Visit **www.aetnamedicare.com** or call **1-833-859-6031 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part B premium is covered for full-dual members.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

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Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary. For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call the number on your ID card if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery. Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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