Aetna Life Insurance Company

Former Employer/Union/Trust Name: **CITY OF HOUSTON**
Group Agreement Effective Date: **01/01/2021**
Group/Account Number: **467658**

This Schedule of Cost Sharing is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the attachment for information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.) If you have questions, please call Member Services at the telephone number listed on your member ID card.

Annual Deductible	
This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered Medicare Part A and B services.	**$150** Deductible waived for Preventive Services, Emergency Room Visits, Emergency Ambulance, Urgent Care, and applicable Riders
Annual Maximum Out-of-Pocket Limit	
The maximum out-of-pocket limit is the most you will pay for covered benefits including any deductible (if applicable).	Combined maximum out-of-pocket amount for in- and out-of-network services: **$3,500**

Important information regarding the services listed below in the Schedule of Cost Sharing:

If you receive services from:	If your plan services include:	You will pay:
A primary care physician (PCP): • Family Practitioner • Pediatrician • Internal Medicine • General Practitioner And get more than one covered service during the single visit:	Copays only	One PCP copay.
	Copays and coinsurance	The PCP copay and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.
An outpatient facility, specialist or doctor who is not a PCP and get more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

Medical Benefits Chart

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

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	You pay a $20 copay for each Medicare-covered acupuncture visit.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are	You pay a $20 copay for each Medicare-covered one-way trip.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required **Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.**	
	Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" preventive visit. You may schedule your annual routine physical once per calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. Please see "**Outpatient diagnostic tests and**	You pay a $0 copay for the exam.

Services that are covered for you		What you must pay (after any deductible listed on page 1) when you get these services
	therapeutic services and supplies" for more information.	
	Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
	Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
	Breast cancer screening (mammograms) Covered services include: • 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	There is no coinsurance, copayment, or deductible for covered screening mammograms. There is no coinsurance, copayment, or deductible for diagnostic mammograms.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay a $20 copay for each Medicare-covered cardiac rehabilitation visit.
	Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
	Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
	Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $15 copay for each Medicare-covered visit.
	Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology, will be covered at $0 copay as these procedures were during a preventive service. If you have had polyps removed during a previous colonoscopy or have a prior history of colon cancer, ongoing colonoscopies are considered diagnostic, are not considered preventive screenings, and are subject to the outpatient surgery cost-sharing. (See "**Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**" for more information.)

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Medicare-covered services include: • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered (non-routine) dental care service.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. You should order your LifeScan starter kit including the model of meter you prefer by contacting LifeScan directly at 1-877-764-5390. Use order code: 123AET200. LifeScan will send you a starter kit in the mail that includes the meter you selected, a small supply of lancets and test strips, as well as usage and educational materials. You should also reach out to your physician to obtain a prescription for LifeScan test strips that you can fill at your network pharmacy.	We cover diabetic supplies made by OneTouch/ LifeScan. We exclusively cover OneTouch/ LifeScan glucose monitors and test strips. We also cover OneTouch/LifeScan lancets, solutions, and lancing devices. We do not cover other brands of monitors and test strips unless you or your provider requests a medical exception and it is approved. Non-LifeScan monitors and test strips without a medical exception, or a medical exception that is not approved, will not be covered. You pay a $0 copay for each Medicare-covered diabetic service or supply from OneTouch/ Lifescan, or from a non-preferred provider when a prior authorization is received. You pay a $0 copay for each pair of Medicare-covered diabetic shoes/inserts. $0 copay for members eligible for the Medicare-covered diabetes self-management training preventive benefit.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Prior authorization rules may apply. Your network provider is responsible for requesting prior authorization.	
	Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.AetnaRetireePlans.com. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay 20% of the total cost for each Medicare-covered item.
	Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	You pay a $80 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, your cost sharing amount for the emergency room visit will be waived.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. This coverage is available worldwide (i.e., outside of the United States).	
Health and wellness education programs • **Fitness Benefit** You are covered for a basic membership to a SilverSneakers® participating fitness facility. At-home fitness kits and online classes are also available for members that do not reside near a participating club or prefer to exercise at home. Members may order one fitness kit per year.	SilverSneakers® Fitness Program is included in your plan. There is no coinsurance, copayment, or deductible for this service. We're here to help and give you more information. • Call us at **1-888-423-4632**. (For TTY/TDD assistance please dial 711.) • Visit www.silversneakers.com to find a participating location near you.
• **24-Hour Nurse Line** Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options.	Included in your plan. There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line service. Call us at **1-800-556-1555**.(For TTY/TDD assistance please dial 711.)

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• **Resources for Living ℠** Resources for Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life related issues.	Included in your plan. There is no coinsurance, copayment, or deductible for this service. Call Resources for Living at **1-866-370-4842**.
• **Written health education materials** Written health education materials, such as plan issued newsletters and websites, and information on community resources.	Included in your plan.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	You pay a $20 copay for each Medicare-covered hearing and balance evaluation.
• Our plan covers one non-Medicare covered hearing exam every 12 months	You pay a $0 copay for the non-Medicare covered hearing exam.
• Hearing aid reimbursement You may see any licensed hearing provider who accepts Medicare patients in the U.S. and has not opted out of Original Medicare. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment. If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing	Our plan will reimburse you up to $500 once every 36 months towards the cost of hearing aids.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
information, which will delay the processing time. Notes: If you use a non-licensed provider you will not receive reimbursement. If you use a provider that has opted out of Medicare you will not receive reimbursement. You are responsible for any charges above the reimbursement amount. Amounts you pay for hearing aids do not count toward your annual maximum out-of-pocket amount.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total	You pay a $0 copay for each Medicare-covered home health visit. You pay 20% of the total cost for each Medicare-covered durable medical equipment item.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You pay a $20 copay for Medicare-covered home infusion therapy professional services, training and education, and monitoring. Please note that home infusion drugs, pumps and devices provided during a home infusion therapy visit are covered separately under your "DME and related supplies" benefit.
	Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, you pay your plan cost-sharing amount for these services. For services that are covered by our plan but are not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.	prognosis are paid for by Original Medicare, not our plan.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*) of your *Evidence of Coverage*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Hospice consultations are included as part of **Inpatient Hospital Care**. Physician service cost sharing may apply for outpatient consultations.
	Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • 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 We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. You pay a $0 copay for other Medicare-covered Part B vaccines. You may have to pay an office visit cost-share if you get other services at the same time that you get vaccinated.
	Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of days covered by our plan. Covered services include but are not limited to:	For Medicare-covered hospital stays, you pay: $250 per stay Cost-sharing is charged for each inpatient stay.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. All components of blood	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
Inpatient mental health care • Covered services include mental health care services that require a hospital stay • There is no limit to the number of days covered by our plan **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	For Medicare-covered hospital stays, you pay: $250 per stay Cost-sharing is charged for each inpatient stay.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your skilled nursing facility (SNF) benefits or if the SNF or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered primary care doctor visit. You pay a $20 copay for each Medicare-covered specialist visit. You pay a $20 copay for each Medicare-covered diagnostic procedure or test. You pay a $20 copay for each Medicare-covered lab service. You pay a $20 copay for each Medicare-covered X-ray. You pay a $20 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $20 copay for each Medicare-covered therapeutic radiology service. You pay a $20 copay for Medicare-covered medical supply items. You pay 20% of the total cost for each Medicare-covered prosthetic and orthotic item. You pay 20% of the total cost for each Medicare-covered DME item. You pay a $20 copay for each Medicare-covered physical, speech or occupational therapy visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Meals Benefit covers up to 14 home-delivered meals over a 7-day period. After discharge from an inpatient hospital stay to your home, you may be eligible to receive meals to help you recover from your injuries or manage your health conditions. To be covered, such meals must be ordered by a licensed health care provider or your Care Manager and may not be merely for convenience or comfort purposes. Meals will be delivered to your home. **Note:** Observation stays do not qualify you for this benefit. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization.**	$0 copay for meals. Covered up to 14 home-delivered meals provided after discharge home from an inpatient hospital stay.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs	You pay a $0 copay per prescription or refill. You pay a $0 copay for each chemotherapy or infusion therapy Part B drug. You pay a $20 copay for the administration of the chemotherapy drug as well as for infusion therapy.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Part B drugs may be subject to step therapy requirements. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: aetna.com/partb-step. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 of the *Evidence of Coverage*. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. All components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests	Your cost-share is based on: • the tests/services/ supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed You pay a $20 copay for each Medicare-covered X-ray. You pay a $20 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $20 copay for each Medicare-covered lab service. You pay a $20 copay for each Medicare-covered diagnostic procedure or test.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	You pay a $20 copay for each Medicare-covered therapeutic radiology service. You pay a $20 copay for Medicare-covered medical supply items.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Your cost share for Observation Care is based upon the Medicare-covered services you receive.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You pay a $0 copay per facility visit. Your cost-share is based on: • the tests/services/ supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed You pay a $20 copay for each Medicare-covered primary care doctor visit. You pay a $20 copay for each Medicare-covered specialist visit. You pay a $20 copay for each Medicare-covered lab service. You pay a $20 copay for each Medicare-covered diagnostic procedure and test. You pay a $20 copay for each Medicare-covered mental health service (individual session). You pay a $20 copay for each Medicare-covered mental health service (group session). You pay a $20 copay for each Medicare-covered X-ray. You pay a $20 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $20 copay for each Medicare-covered therapeutic radiology service. You pay a $20 copay for each Medicare-covered partial hospitalization visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	You pay a $20 copay for Medicare-covered medical supply items. You pay a $0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself. You pay a $80 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, your cost sharing amount for the emergency room visit will be waived.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. We also cover some telehealth visits with psychiatric and mental health professionals. See "**Physician/Practitioner services, including doctor's office visits**" for information about telehealth outpatient mental health care. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered mental health service (individual session). You pay a $20 copay for each Medicare-covered mental health service (group session).
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy.	You pay a $20 copay for each Medicare-covered outpatient rehabilitation service visit.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Outpatient substance abuse services Our coverage is the same as Original Medicare which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief interventions or advice focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior**	For each Medicare-covered outpatient substance abuse session, you pay $20

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	
	Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost-share is based on: • the tests/services/supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed. You pay a $0 copay for each Medicare-covered outpatient hospital facility visit. You pay a $0 copay for each Medicare-covered ambulatory surgical center visit.
	Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services

Physician/Practitioner services, including doctor's office visits
 	
Covered services include:
• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location
• Consultation, diagnosis, and treatment by a specialist
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment
• Certain telehealth services, including:
  ○ Primary care physician services
  ○ Mental health services (individual sessions)
  ○ Mental health services (group sessions)
  ○ Psychiatric services (individual sessions)
  ○ Psychiatric services (group sessions)
  ○ Urgently needed services
  ○ This coverage is in addition to the telehealth services described below. For more details on your additional telehealth coverage, please review the Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth.
  ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.
  ○ Members should contact their doctor for information on what
	Your cost-share is based on:
	• the tests/services/ supplies you receive
	• the provider of the tests/services/ supplies
	• the setting where the tests/services/ supplies are performed
	
	You pay a $20 copay for each Medicare-covered primary care doctor visit (including telehealth services, nationally contracted walk-in clinic services, and urgently needed services).
	
	You pay a $20 copay for each Medicare-covered specialist visit (including surgery second opinion, telehealth services, and urgently needed services).
	
	You pay a $20 copay for each Medicare-covered hearing and balance exam.
	
	Certain additional telehealth services, including those for:
	
	You pay a $20 copay for each primary care physician service.
	
	You pay a $20 copay for each mental health service (individual sessions).
	
	You pay a $20 copay for each mental health service (group sessions).
	
	You pay a $20 copay for each psychiatric service (individual sessions).
	
	You pay a $20 copay for each psychiatric service (group sessions).
	
	You pay a $20 copay for each urgently needed service.
	
	You pay a $20 copay for each Medicare-covered (non-routine) dental care service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a MinuteClinic Video Visit. Members can find out if these visits are available in their area at www.cvs.com/minuteclinic/virtual-care/video-visit. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	• Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	You pay a $20 copay for each Medicare-covered podiatry service.
	Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
	Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and	You pay 20% of the total cost for each Medicare-covered item.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay a $20 copay for each Medicare-covered pulmonary rehabilitation visit.
	Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the Evidence of Coverage) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	You pay a $0 copay for self-dialysis training and kidney disease education services. You pay a $20 copay for in- and out-of area outpatient dialysis. See "**Inpatient Hospital Care**" for more information on Inpatient services You pay 20% of the total cost for home dialysis equipment and supplies. You pay a $0 copay for Medicare-covered home support services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") We cover 100 days per benefit period. A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs	For Medicare-covered SNF stays, you pay: $0 copay per day, day(s) 1-20; $75 copay per day, day(s) 21-100 A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	• Physician/Practitioner services **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
	Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training	You pay a $20 copay for each Medicare-covered session.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Transportation services (non-emergency transportation that is not covered by Medicare) Coverage includes trips to and from providers or facilities for services that your plan covers. The transportation service will accommodate urgent requests for hospital discharge, dialysis and trips that your medical provider considers urgent. The service will try to accommodate specific physical limitations or requirements. However, it limits services to wheelchair, taxi or sedan transportation vehicles. • Transportation services are administered through Access2Care • To arrange for transport, call **1-855-814-1699**, Monday through Friday, from 8 a.m. to 8 p.m., in all time zones. (For TTY/TDD assistance please dial 711.) • You must schedule transportation service at least 72 hours before the appointment	$0 copay per trip. We cover 24 one-way trips to and from plan-approved locations each year. Trips must be within 60 miles of provider location.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	• You must cancel more than two hours in advance, or Access2Care will deduct the trip from the remaining number of trips available • This program doesn't support stretcher vans/ambulances • The driver's role is limited to helping the member in and out of the vehicle	
	Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Coverage is available worldwide (i.e., outside of the United States).	You pay a $20 copay for each Medicare-covered urgent care visit received at an urgent care facility.
	Vision care Covered services include:	
	• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	You pay a $20 copay for exams to diagnose and treat diseases and conditions of the eye.
	• For people who are at high risk of glaucoma, we will cover 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	You pay a $0 copay for one glaucoma screening every 12 months.
	• For people with diabetes, screening for diabetic retinopathy is covered once per year	You pay a $0 copay for one diabetic retinopathy screening every 12 months.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	You pay a $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals.
Our plan covers one non-Medicare covered eye exam every 12 months.	You pay a $0 copay for one non-Medicare covered eye exam.
Contact lenses, prescription lenses and frames: Eyewear reimbursement, excluding eyeglasses or contact lenses after cataract surgery (this amount does not count toward the maximum out-of-pocket amount)	Our plan will reimburse you up to $70 once every 24 months towards the cost of eyewear.
You may see any licensed vision provider who accepts Medicare patients in the U.S. and has not opted out of Original Medicare. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment., If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing information, which will delay the processing time.	
Notes: If you use a non-licensed provider you will not receive reimbursement. If you use a provider that has opted out of Medicare you will not receive reimbursement. You are responsible for any charges above the reimbursement amount.	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

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

Aetna Life Insurance Company

Former Employer/Union/Trust Name: CITY OF HOUSTON
Group Agreement Effective Date: 01/01/2021
Group/Account Number: 467658

This *Prescription Drug Schedule of Cost Sharing* is part of the *Evidence of Coverage* (EOC) for our plan. When the EOC refers to the attachment for details of Medicare Part D prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart. (See the EOC chapters titled "Using the plan's coverage for your Part D prescription drugs" and "What you pay for your Part D prescription drugs.")

Annual Deductible Amount:	$0
Formulary Type:	GRP B2
Number of Cost Share Tiers:	5 Tier
Initial Coverage Limit:	$4,130
True Out-of-Pocket Amount:	$6,550

Retail Pharmacy Network: P1

The name of your pharmacy network is listed above. The Aetna Medicare pharmacy network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost-sharing may be less at pharmacies with preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs.

The pharmacy network includes limited lower-cost, preferred pharmacies in **rural areas of Kansas, Maine, Michigan, and Nebraska, suburban areas of Arizona and West Virginia, and urban areas of Michigan.** The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. To find a network pharmacy, or find up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Member Services at the number on the back of your member ID card or consult the online *Pharmacy Directory* at www.AetnaRetireePlans.com.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

Every drug on the plan's Drug List is in one of the cost-sharing tiers described below:

- Tier One – Preferred generic drugs: Includes low-cost generic drugs
- Tier Two – Generic drugs: Includes generic drugs
- Tier Three – Preferred brand drugs: Includes preferred brand drugs and some high-cost generic drugs
- Tier Four – Non-preferred drugs: Includes non-preferred brand drugs and some higher-cost generic drugs
- Tier Five – Specialty drugs: Includes high-cost/unique brand and generic drugs

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List. If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Initial Coverage Stage: Amount you pay, up to $4,130 in total covered prescription drug expenses.

Standard Cost Share: Chart below lists amount you pay at a pharmacy that offers standard cost sharing**:**

Initial Coverage	**One-Month Supply**			**Extended Supply**	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	You pay $5	You pay $5	You pay $5	You pay $10	You pay $4
Tier 2 Generic drugs - Includes generic drugs	You pay $20	You pay $20	You pay $20	You pay $40	You pay $20

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	You pay $40	You pay $40	You pay $40	You pay $80	You pay $80
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	You pay $75	You pay $75	You pay $75	You pay $150	You pay $150
Tier 5 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Preferred Cost Share: Chart below lists amount you pay at a pharmacy that offers preferred cost sharing**:**

Initial Coverage	One-Month Supply			Extended Supply	
	Preferred retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Preferred retail cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	You pay $2	You pay $5	You pay $5	You pay $4	You pay $4
Tier 2 Generic drugs - Includes generic drugs	You pay $10	You pay $20	You pay $20	You pay $20	You pay $20
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	You pay $40	You pay $40	You pay $40	You pay $80	You pay $80
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	You pay $75	You pay $75	You pay $75	You pay $150	You pay $150

Initial Coverage	One-Month Supply			Extended Supply	
	Preferred retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Preferred retail cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 5 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Coverage Gap Stage: Amount you pay after you reach $4,130 in total covered prescription drug expenses and until you reach $6,550 in out-of-pocket covered prescription drug costs.

Your plan's gap coverage is listed in the chart below.

Standard Cost Share: Chart below lists amount you pay, during the coverage gap, at a pharmacy that offers standard cost sharing**:**

Supplemental Gap Coverage	**One-Month Supply**			**Extended Supply**	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	You pay $5	You pay $5	You pay $5	You pay $10	You pay $4
Tier 2 Generic drugs - Includes generic drugs	You pay $20	You pay $20	You pay $20	You pay $40	You pay $20
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	You pay $40	You pay $40	You pay $40	You pay $80	You pay $80
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	You pay $75	You pay $75	You pay $75	You pay $150	You pay $150

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 5 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

***Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Preferred Cost Share: Chart below lists amount you pay, during the coverage gap, at a pharmacy that offers preferred cost sharing**:**

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Preferred retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Preferred retail cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	You pay $2	You pay $5	You pay $5	You pay $4	You pay $4
Tier 2 Generic drugs - Includes generic drugs	You pay $10	You pay $20	You pay $20	You pay $20	You pay $20
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	You pay $40	You pay $40	You pay $40	You pay $80	You pay $80
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	You pay $75	You pay $75	You pay $75	You pay $150	You pay $150

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Preferred retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Preferred retail cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 5 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*****Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching $6,550 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount: –*either* – coinsurance of 5% of the cost of the drug–*or*– $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs. Our plan pays the rest of the cost.

Step Therapy

Your plan includes step therapy. This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

This Plan Uses the GRP B2 Formulary:

Your plan uses the GRP B2 formulary, which means that only drugs on Aetna's drug list will be covered under your plan as long as the drug is medically necessary, and the plan rules are followed. Tiers labeled as brand, preferred brand, and non-preferred drug will also include some high-cost generic drugs. Non-preferred copayment levels may apply to some drugs on the drug list. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2021 Group Formulary (List of Covered Drugs)* for more information.

Online documents make it easy to find the info you need

Did you know? Your essential plan documents are online at **AetnaRetireePlans.com**. This includes your Evidence of Coverage (EOC) and your plan's formulary, too. Online documents are **kinder to the environment** — saving both trees and landfill space. And they're **more portable**, too. You can access them anytime, anywhere, from any device, no matter if it's your computer, tablet or smartphone.

Save time when you search online

You can usually locate info more quickly in an online document by:

- Pressing the **"CTRL" and "F" keys** at the same time on your computer keyboard
- Clicking the magnifying glass icon () on your smartphone or tablet

Both allow you to jump to specific words or phrases wherever they appear in the document.

Prefer larger text?

Simply use the "zoom" feature on your device or web browser to make the text larger.

Get to know your plan documents

Your EOC: a guide to what's covered

Your **EOC** is a description of coverage under your Medicare plan. It also outlines how to get services and your member rights.

Your formulary: a list of prescription drugs your plan covers

Along with the drug name, the formulary has each drug's tier level, which can affect how much you'll pay for the drug. It also lists any special requirements, such as prior authorization, quantity limits or step therapy.

> **Tip: how to use the formulary**
> Online you can get a list of all the prescription drugs we cover or just look for a specific drug. In the full drug list, or formulary, we show drugs under the medical condition they're used to treat (such as "Antiviral") and in an alphabetical index. This makes it easier for you and your doctor to find a drug that works best with your treatment plan.

Your provider directory: the key to unlocking our provider network

Your provider directory lists the doctors, hospitals and health care facilities in your plan's network. In it you'll find primary care physicians, specialists such as cardiologists and podiatrists, and other providers to help you reach your best health.

Rest assured, even if your doctor or hospital doesn't appear in the provider directory network, you may still be able to see them depending on your plan. You may pay more for out-of-network services. Please check your EOC or call us at the number on your member ID card.

Your pharmacy directory: a road map for finding a network pharmacy
Our pharmacy network includes national chains as well as local options for your prescription drugs. You'll find a list of them in your pharmacy directory.

Be sure you have the most up-to-date info. Your 2021 documents are currently available on our website. To view/download your documents:

Material	Where to find 2021 info	Call to request printed material
Your EOC name **ESA with RX**	**AetnaRetireePlans.com**	**Call** **1-866-325-5908**
Your Formulary name **2021 GRP B2 (5 Tier)** **Formulary - MAPD**	**AetnaRetireePlans.com**	**Call** **1-866-325-5908**
Pharmacy directory	**AetnaRetireePlans.com**	**Call the number on your ID card**
Provider directory	**AetnaRetireePlans.com**	**Call the number on your ID card**

We're here to help

Need help finding a network provider who accepts the plan or Pharmacy? Want to know if your prescription is covered? Just have general questions about your plan? Simply call us at the number on your member ID card.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

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.

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.

The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary.

Y0001_GRP_0009_3055A_2021_C
72.30.404.1

aetna™ Notice of Privacy Practices

Para recibir esta notificación en español por favor llamar al número gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificación.

若要以西班牙文或中文接收本通知，請致電 ID 卡上的會員服務部免付費電話。

To receive this notice in Spanish or Chinese, please call the toll-free Member Services number on your ID card.

This Notice of Privacy Practices applies to Aetna's insured health benefit plans. It does not apply to any plans that are self-funded by an employer. If you receive benefits through a group health insurance plan, your employer will be able to tell you if your plan is insured or self-funded. If your plan is self-funded, you may want to ask for a copy of your employer's privacy notice.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Aetna[1] considers personal information to be confidential. We protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information.

When we use the term "personal information," we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care).

This notice became effective on October 9, 2018.

How Aetna Uses and Discloses Personal Information

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and health care providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

Health Care Operations: We may use and disclose personal information during the course of running our health business – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all of the HMO and licensed insurer subsidiaries of Aetna Inc., including but not limited to the entities listed on the last page of this notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). In addition, we make claims information contained on our secure member website and telephonic claims status sites available to the subscriber and all covered dependents. We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, if you receive benefits through a group health insurance plan, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

Additional Reasons for Disclosure

We may use or disclose personal information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** (Group Plans)– to your employer, as applicable, when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Associates** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to Government agencies that regulate us (different countries and U.S. state insurance departments).
- **Workers' Compensation** – to comply with workers' compensation laws.
- **Law Enforcement** – to Government law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).
- **As Required by Law** – to comply with legal obligations and requirements.
- **Decedents** – to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or as authorized by law; and to funeral directors as necessary to carry out their duties.
- **Organ Procurement** – to respond to organ donation groups for the purpose of facilitating donation and transplantation.

Required Disclosures: We **must** use and disclose your personal information in the following manner:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, as necessary, for HIPAA compliance and enforcement purposes.

Disclosure to Others Involved in Your Health Care

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Member Services number on your ID card – or have your provider contact us.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

- for marketing purposes that are unrelated to your benefit plan(s),
- before disclosing any psychotherapy notes,
- related to the sale of your health information, and
- for other reasons as required by law.

If you have given us an authorization, you may revoke it in writing at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Member Services number on your ID card.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information:

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information (e.g. Explanation of benefits (EOB) and other claim information) to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with health care operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your health care.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request.
- You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews.[1]

[1] Aetna does not participate in pretext interviews.

You may make any of the requests described above (if applicable), may request a paper copy of this notice, or ask questions regarding this notice by calling the toll-free Member Services number on your ID card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address:

HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079

You may stop the paper mailing of your EOB and other claim information by visiting **www.aetnamedicare.com** and click "Log In/Register". Follow the prompts to complete the one-time registration. Then you can log in any time to view past copies of EOBs and other claim information.

You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Aetna's Legal Obligations

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

Coverage may be underwritten or administered by one or more of the following companies: Aetna Health Inc.; Aetna Health of California Inc.; Aetna Dental of California Inc.; Group Dental Service of Maryland Inc.; Aetna Health of the Carolinas Inc.; Aetna Health of Illinois Inc.; Aetna Dental Inc.; Aetna Health of Washington Inc.; Aetna Life Insurance Company; Aetna Insurance Company of Connecticut; Aetna Health Insurance Company of Connecticut; and Aetna Health Insurance Company of New York. Mail order pharmacy services may be provided by Aetna R_x Home Delivery, LLC.

We comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We:

- Provide 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)
- Provide 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, call Customer Service at the phone number on your benefit ID card.

If you believe that we have 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 our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service at the phone number on your benefit ID card.

If you speak a language other than English, free language assistance services are available. Visit our website or call the phone number listed in this document. (English)

Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento. (Spanish)

如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。(Traditional Chinese)

Kung hindi Ingles ang wikang inyong sinasalita, may maaari kayong kuning mga libreng serbisyo ng tulong sa wika. Bisitahin ang aming website o tawagan ang numero ng telepono na nakalista sa dokumentong ito. (Tagalog)

Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique gratuits vous sont proposés. Visitez notre site Internet ou appelez le numéro indiqué dans ce document. (French)

Nếu quý vị nói một ngôn ngữ khác với Tiếng Anh, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin vào trang mạng của chúng tôi hoặc gọi số điện thoại ghi trong tài liệu này. (Vietnamese)

Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Besuchen Sie unsere Website oder rufen Sie die Telefonnummer in diesem Dokument an. (German)

영어가 아닌 언어를 쓰시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 저희 웹사이트를 방문하시거나 본 문서에 기재된 전화번호로 연락해 주십시오. (Korean)

Если вы не владеете английским и говорите на другом языке, вам могут предоставить бесплатную языковую помощь. Посетите наш веб-сайт или позвоните по номеру, указанному в данном документе. (Russian)

إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متاحة. تفضل بزيارة موقعنا على الويب أو اتصل برقم الهاتف المدرج في هذا المستند. (Arabic)

अगर आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट परजाएं या इस दस्तावेज़ में दिए गए फोन नंबर पर कॉल करें। (Hindi)

Nel caso Lei parlasse una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Visiti il nostro sito web oppure chiami il numero di telefono elencato in questo documento. (Italian)

Caso você seja falante de um idioma diferente do inglês, serviços gratuitos de assistência a idiomas estão disponíveis. Acesse nosso site ou ligue para o número de telefone presente neste documento. (Portuguese)

Si ou pale yon lòt lang ki pa Anglè, wap jwenn sèvis asistans pou lang gratis ki disponib. Vizite sitwèb nou an oswa rele nan nimewo telefòn ki make nan dokiman sa a. (Haitian Creole)

Jeżeli nie posługują się Państwo językiem angielskim, dostępne są bezpłatne usługi wsparcia językowego. Proszę odwiedzić naszą witrynę lub zadzwonić pod numer podany w niniejszym dokumencie. (Polish)

英語をお話しにならない方は、無料の言語支援サービスを受けることができます。弊社のウェブサイトにアクセスするか、または本書に記載の電話番号にお問い合わせください。(Japanese)

Nëse nuk flisni gjuhën angleze, shërbime ndihmëse gjuhësore pa pagesë janë në dispozicionin tuaj. Vizitoni faqen tonë në internet ose merrni në telefon numrin e telefonit në këtë dokument. (Albanian)

ከእንግሊዝኛ ሌላ ቋንቋ የሚናገሩ ከሆነ ነጻ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይቻላል። የእኛን ድረ-ገጽ ይጎብኙ ወይም በዚህ ሰነድ ላይ የተዘረዘረውን ስልክ ቁጥር በመጠቀም ይደውሉ። (Amharic)

Եթե խոսում եք անգլերենից բացի մեկ այլ լեզվով, ապա Ձեզ համար հասանելի են լեզվական աջակցման անվճար ծառայություններ: Այցելեք մեր վեբ կայքը կամ զանգահարեք այս փաստաթղթում նշված հեռախոսահամարով: (Armenian)

যদি আপনি ইংরেজী ব্যতীত অন্য কোনো ভাষায় কথা বলেনতাহলে বিনামূল্যের দোভাষীর পরিষেবা উপলব্ধ আছে।আমাদের ওয়েবসাইট দেখুন এবং এই নথিতে তালিকাভুক্ত ফোন নম্বরে ফোন করুন। (Bengali)

បើលោកអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនដោយឥតគិតថ្លៃ។ សូមចូលមើលគេហទំព័ររបស់យើងខ្ញុំ ឬហៅទៅកាន់លេខទូរស័ព្ទដែលមាននៅក្នុងឯកសារនេះ។ (Khmer)

Ako govorite neki jezik koji nije engleski, dostupne su besplatne jezičke usluge. Posetite našu internet stranicu ili nazovite broj telefona navedenog u ovom dokumentu. (Serbo-Croatian)

Na ye jam thuɔŋdɛ̈t tënë thoŋ ë Dïŋlïth, ke kuɔɔny luilooi ë thok ë path aa tɔ̈ thïn. Nem ɣöt tɛ̈n internet tɛ̈dë ke yï cɔl akuën cɔ̈tmec cï gat thin në athör du yic. (Dinka)

Als u een andere taal spreekt dan Engels, is er gratis taalondersteuning beschikbaar. Bezoek onze website of bel naar het telefoonnummer in dit document. (Dutch)

Εάν ομιλείτε άλλη γλώσσα εκτός της Αγγλικής, υπάρχουν δωρεάν υπηρεσίες στη γλώσσα σας. Επισκεφθείτε την ιστοσελίδα μας ή καλέστε τον αριθμό τηλεφώνου που αναγράφεται στο παρόν έγγραφο. (Greek)

જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. અમારી વેબસાઇટની મુલાકાત લો અથવા દસ્તાવેજમાં સૂચીબદ્ધ કરવામાં આવેલ ફોન નંબર પર કૉલ કરો. (Gujarati)

Yog hais tias koj hais ib hom lus uas tsis yog lus Askiv, muaj cov kev pab cuam txhais lus dawb pub rau koj. Mus saib peb lub website los yog hu rau tus xov tooj sau teev tseg nyob rau hauv daim ntawv no. (Hmong)

ຖ້າທ່ານເວົ້າພາສານອກເໜືອຈາກອັງກິດ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າແມ່ນມີໃຫ້ທ່ານ. ໄປທີ່ເວັບໄຊທ໌ຂອງພວກເຮົາ ຫຼື ໂທຕາມເບີໂທລະສັບທີ່ລະບຸໃນເອກະສານນີ້. (Lao)

Bilagáana bizaad doo bee yáníłti’da dóó saad nááná ła’ bee yáníłti’go, ata’ hane’ t’áá jíík’e bee áká i’doolwołígíí hóló̜. Béésh nitsékeesí bee na’ídíkid bá haz’ánígi ąą’ádíílííł éí doodago béésh bee hane’í bee nihich’į’ hodíílnih díí naaltsoos bikáá’íjį’. (Navajo)

Wann du en Schprooch anners as Englisch schwetzscht, Schprooch Helfe mitaus Koscht iss meeglich. Bsuch unsere Website odder ruf die Nummer uff des Document uff. (Pennsylvania Dutch)

اگر به‌زبان دیگری بجز انگلیسی گفتگو می کنید، کمک زبانی رایگان فراهم می باشد. به وبسایت ما مراجعه نمایید و یا به شماره تلفن که در سند ذیل لست شده، تماس بگیرید. (Farsi)

ਜੇ ਤੁਸੀਂ ਅੰਗ੍ਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਸਾਡੀ ਵੈੱਬਸਾਈਟ 'ਤੇ ਜਾਓ ਜਾਂ ਿਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

Dacă vorbiți o altă limbă decât engleza, aveți la dispoziție servicii gratuite de asistență lingvistică. Vizitați site-ul nostru sau sunați la numărul de telefon specificat în acest document. (Romanian)

ܐܢ ܐܢܬܘܢ ܟܕ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܚܪܢܐ ܠܐ ܠܫܢܐ ܐܢܓܠܝܙܝܐ، ܐܝܬ ܦܘܠܚܢܐ ܕܡܓܢܐ ܠܡܥܕܪܢܘܬܐ ܕܠܫܢܐ. ܣܥܘܪܘܢ ܠܨܘܪܬܢ ܐܠܟܬܪܘܢܝܬܐ، ܐܘ ܩܪܘ ܠܢ ܥܠ ܡܢܝܢܐ ܕܬܠܦܘܢ ܕܟܬܝܒ ܒܗܢܐ ܕܘܟܝܡܢܛܐ (Syriac)

หากคุณพูดภาษาอื่นนอกเหนือจากภาษาอังกฤษ สามารถขอรับบริการช่วยเหลือด้านภาษาได้ฟรี เข้าไปที่เว็บไซต์ของเรา หรือโทรติดต่อหมายเลขโทรศัพท์ที่แสดงไว้ในเอกสารนี้ (Thai)

Якщо ви не говорите англійською, до ваших послуг безкоштовна служба мовної підтримки. Відвідайте наш веб-сайт або зателефонуйте за номером телефону, що зазначений у цьому документі. (Ukrainian)

اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، زبان سے متعلق مدد کی مفت خدمات دستیاب ہیں۔ ہماری ویب سائٹ ملاحظہ کریں یا اس دستاویز میں درج فون نمبر پر کال کریں۔ (Urdu)

אויב איר רעדט א שפראך אויסער ענגליש, זענען שפראך הילף סערוויסעס אוועילעבל. באזוכט אונזער וועבזייטל אדער רופט דעם טעלעפאן נומער וואס שטייט אויף דעם דאקומענט. (Yiddish)

جے تُسی انگریزی تُوں علاوہ کوئی زبان بولدے او، تے مُفت لسانی معاونت دیاں خدمتاں دستیاب نیں۔ ساڈی ویب سائٹ ملاحظہ کرو یا دستاویز (Punjabi)

Just for you

Welcome to your Aetna Medicare Advantage plan

AetnaRetireePlans.com

72.02.444.1 (9/20)

aetna®

Welcome

We're glad you're a member of our Aetna® Medicare plan. We created this handbook with you in mind. That means the whole you — body, mind and spirit. Inside, you'll find useful information and tips to help you make the most of your Medicare plan and help you reach your best health.

Thanks for being a valued member of the Aetna family. We're excited to help you fulfill your health goals.

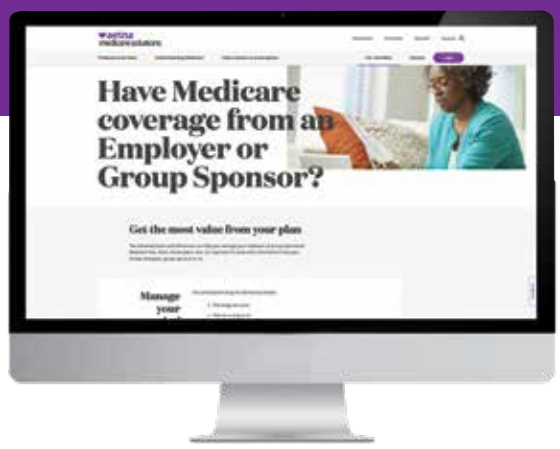
What's inside?

Getting started

Get off to a great start by following these three easy steps:

1 Sign up for your secure member website

Get the most out of your benefits with our online tools to help guide your health goals. Whether you want to see your member ID card, find doctors or other medical professionals, view your claims or look up your medications, we've got you covered.



Register for or log in to the member website using your Aetna member ID card at **AetnaRetireePlans.com**.

You'll also find information on extras that come with your Aetna Medicare Advantage plan. This includes **access to discounts** on items like weight management programs, medical alert systems and oral health care.

2 Get to know your benefits

You can find complete benefits information for your plan in your Evidence of Coverage (EOC) and Schedule of Cost Sharing (SOC). These have detailed information on your coverage, costs and rules you need to follow. Your SOC is in this packet.

Refer to the letter included with this booklet to find out which EOC and formulary — the list of drugs we cover — your plan uses. You'll need to know the formulary name and number of tiers.

Visit **AetnaRetireePlans.com** to view these documents.

3 Find providers and select a primary care physician (PCP)

It's important to have a solid support system. Your PCP can coordinate your care to help you better manage your health. Check your EOC to see if your plan requires you to have a PCP on file with us, or if you can see providers both in and outside of our network and still be covered. Providers must be eligible to receive Medicare payment and accept your plan.

Find doctors and hospitals in the Aetna network here:

AetnaRetireePlans.com

Telehealth vs. urgent vs. emergency care

If you're suddenly sick or injured, your first thought may be to head to the emergency room (ER). However, depending on your medical issue, the ER may not be the best choice. Telehealth and urgent care facilities can offer a more convenient way to get quick care.

Please note that this is not a complete list of reasons to visit an urgent care center or emergency room. If you have of a medical emergency, call **911** or go to the closest ER.

	Telehealth	Urgent care center	Emergency room (ER)
Purpose	Many providers now offer videoconferencing appointments — you can contact your doctor to find out what telehealth services they offer.	These centers offer treatment for injuries or illnesses that are not life threatening.	The ER offers treatment for serious injuries or illnesses.
Advantages	Allows you to receive care when an in-person visit isn't possible or required	Conveniently accepts both walk-ins and appointments, may provide faster treatment, flexible hours	Offers emergency care, treats more serious health issues, open 24/7
Examples of when to go	• Brief virtual check-ins with your primary care physician • Remote evaluation of pre-recorded video and/or images sent to your doctor • Mental health services (individual and group sessions) • Second opinion by another network provider before surgery	• Allergies • Coughing • Upset stomach • Sinus infection • Broken bones • Sore throat • Flu symptoms • Pink eye • Ear infections • Cuts, bumps or sprains	• Difficulty breathing • Loss of consciousness • Severe burns • Chest pain or suspected heart attack • Severe bleeding • Acute stomach pain • Poisoning

Your prescriptions

Throughout the year, how much you pay for medicines will vary based on what drug payment stage you are in.

Deductible: Amount varies per plan

If your plan has a deductible, you usually pay the full discounted price of your drugs, up to the deductible amount. **Once you reach the deductible amount, you pay a copayment or coinsurance in the initial coverage stage**.

Initial coverage: Up to $4,130

In this stage, you pay a cost share for the discounted price of each prescription you fill until your total drug costs reach a certain amount. **Once your total drug cost is $4,130, you enter the coverage gap stage**.

Coverage gap: Up to $6,550

The coverage gap stage, sometimes referred to as the "donut hole," is a gap in coverage in which you may have to pay more for your prescription drugs. **Once your yearly out-of-pocket costs reach $6,550, you move to the catastrophic coverage stage**.

Catastrophic: Through the end of the year

Most members will not reach this final stage. Cost share in this stage is generally lower. Please check your Schedule of Cost Sharing for more information.

Check your enclosed Schedule of Cost Sharing for what you will pay in each phase of coverage.

Cost management tips

1. To check the cost of your drug, you need to know what tier it's on. Your formulary tells you the tier. Generally, the lower the tier, the less you pay. Your Evidence of Coverage and Schedule of Cost Sharing show you the drug cost for each tier.
2. Make an appointment with your doctor and refer to your formulary.
3. To save money, ask if there are covered alternatives on a lower tier.

Your prescriptions

Prescription coverage

To get the most out of your coverage, use these helpful tips:

Find a pharmacy

With access to thousands of pharmacies in our nationwide network, you can get the medications you need for your physical and mental well-being.

Visit **AetnaRetireePlans.com** to find a pharmacy in your network.

Medicines conveniently delivered to your home

CVS Caremark Mail Service Pharmacy™ provides home-delivery services for the medications you take regularly. You can avoid trips to the pharmacy by ordering your medication on the phone or by mail.

For more information, visit **AetnaMedicare.com/rxdelivery** or call the number on your member ID card.

Medication therapy

Our Medication Therapy Management program helps you and your doctor manage your medicines. A pharmacist will review your medications and talk to you about drug therapy, side effects or any questions you may have.

Your formulary drug list

At Aetna®, we have a broad list of covered drugs. It's always good to check what your prescription drugs will cost. To do this, you will need to know what tier your drugs are on.

Locate your formulary at **AetnaRetireePlans.com**.

Get extra support

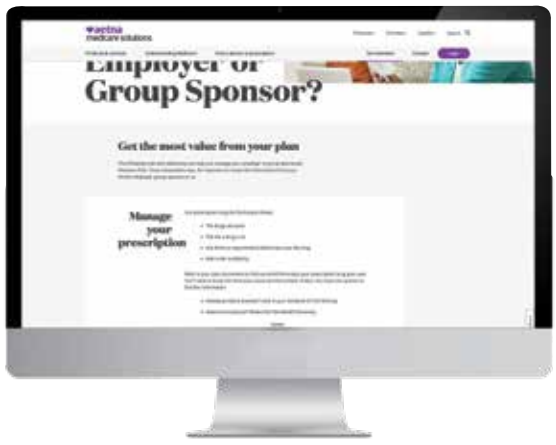
Specialty medicines help people with complex conditions and may require special shipping or storage. With our Specialty Pharmacy medicine and support services, you'll get reliable and secure delivery at no extra cost.

Call **1-800-237-2767 (TTY: 711)** or visit **CVSSpecialty.com**.

Get a 90-day supply

Are there medicines you take regularly to maintain your health? With a 90-day supply you can save time and potentially money by refilling your prescriptions just once every three months.

Talk to your doctor to see if a 90-day supply is right for you.



Medicare key terms

Coinsurance — This is the amount you may have to pay for your share of services. Coinsurance is usually a percentage (for example, 20 percent).

Copayment (copay) — This is the amount you may have to pay for your share of services. Copays are usually a set amount (for example, $10 for a prescription drug or $20 for a doctor visit).

Cost sharing — These are amounts that your plan may require you to pay for your care. Examples of cost sharing can include deductibles, copays or coinsurance.

Deductible — This is the amount some plans require you to pay for covered services before the plan starts to pay.

Drug tiers — This is a group of drugs on a formulary. Each group or tier requires a different level of payment. Higher tiers usually means you'll pay more for the drugs. For example, a drug on Tier 2 generally will cost more than a drug on Tier 1.

Explanation of Benefits (EOB) — An EOB is a notice explaining charges, payments or any balances owed after a doctor or pharmacy you have visited submits a claim. It may be sent by mail or electronically.

Evidence of Coverage (EOC) — This document gives you detailed information on your plan's coverage, costs, and your rights and responsibilities as a plan member.

Formulary — This is a list of prescription drugs the health plan covers. It can include drugs that are brand name and generic. Drugs on this list may cost less than drugs that are not on the list. How much a plan covers may vary from drug to drug. An open formulary provides a greater choice of covered drugs. It is also called a preferred drug list.

In network — This means we have a contract with that doctor or other health care provider. We negotiate reduced rates with them to help you save money. Some plans give you access to both in- and out-of-network providers, as long as they are eligible to receive Medicare payment and accept your plan. Check your plan documents.

Maintenance medications — These are prescription drugs that you take on a regular basis. These drugs help treat chronic conditions, such as for asthma, diabetes, high blood pressure and other health conditions. You may be able to save money on your maintenance prescriptions by filling them for a 90-day supply at retail and/or mail order.

Mail-order pharmacy — A convenient service where you can have your medications delivered directly to your door. The preferred mail-order service available with your plan is CVS Caremark Mail Service Pharmacy™.

Premium — This is the amount you may pay your plan for coverage.

Schedule of Cost Sharing (SOC) — This shows the share of costs covered by Aetna that you pay out of your own pocket. It can include deductibles, coinsurance copayments, or similar charges.

Urgent care centers — These centers can treat urgent, but non-life-threatening, medical issues. A few examples are sprains, fractures and minor burns. If you have a medical issue that threatens your life, always visit the nearest emergency room or call **911** first.

Extras you get with Aetna®

Healthy Home Visits

Get a home visit from a licensed doctor or nurse to assess your health and safety needs.

Case management

Personalized nurse support is available if you need help managing any chronic conditions.

Resources For Living®

Get referrals to services in your area that offer help such as household chores, transportation, community resources, and more.

To contact our Resources For Living team, call 1-866-370-4842 (TTY: 711).

24/7 nurse hotline

Speak with a registered nurse any time, night or day, on any health-related topic.

Just call 1-800-556-1555 (TTY: 711).

If you need more information about any of our extra benefits, call the number on your Aetna member ID Card.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. 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. 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. Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. The member is responsible for the full cost of discounted services. Aetna may receive a percentage of the fee paid to a discount vendor.

Y0001_GRP_0009_3205_2021_C
72.02.444.1 (9/20)

aetna®

AetnaRetireePlans.com