



2026 Summary of Benefits

CITY OF WILMINGTON

Sponsored by Aetna Medicare Plan (PPO)
Medicare (C04) ESA PPO Plan, Rx \$10/\$20/\$35

Keep in mind

This is just a summary. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage (EOC)*. You can request a copy of the SOC/EOC by contacting:

Member Services

1-888-267-2637 (TTY: 711)

Hours are 8 AM to 9 PM ET, Monday through Friday.

Are you eligible to enroll?

To join Aetna Medicare Plan (PPO), you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area



This is a summary of the services we cover from January 1, 2026 through December 31, 2026.



Service area: A complete list of service areas can be found in the *Evidence of Coverage (EOC)*.



What You Should Know

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Plan costs & information	Network & Out-of-network providers
Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible	<p>\$0</p> <p>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.</p>
Annual Maximum Out-of-Pocket	<p>\$0</p> <p>The maximum out-of-pocket (MOOP) is the most you'll pay for the medical services we cover each year. It's in place to protect you. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.</p>

PRIMARY BENEFITS	Your costs for in and out-of-network care
Hospital Care*	
Inpatient Hospital Care	\$0 per stay The member cost sharing applies to covered benefits incurred during a member’s inpatient stay.
Observation Stay	Your cost share for Observation Care is based upon the services you receive.
Frequency	per stay
Outpatient Hospital Services and Surgery	\$0
Ambulatory Surgery Center	\$0
Physician Services	
Primary Care Provider Visits	\$0 Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.
Physician Specialist Visits	\$0
Preventive Services	
Medicare-covered Preventive Services	\$0
<ul style="list-style-type: none"> • Abdominal aortic aneurysm screenings • Alcohol misuse screenings and counseling • Annual Wellness visit • Bone mass measurements • Breast cancer screening: mammogram • Cardiovascular behavior therapy • Cardiovascular disease screenings • Cervical and vaginal cancer screenings • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screenings • Diabetes screenings • HIV screenings • Lung cancer screenings and counseling • Medicare Diabetes Prevention Program • Medical nutrition therapy 	

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PRIMARY BENEFITS	Your costs for in and out-of-network care
Preventive Services (continued)	
<ul style="list-style-type: none"> • Obesity behavior therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit 	
Immunizations <ul style="list-style-type: none"> • Flu • Hepatitis B • Pneumococcal 	\$0
Additional Medicare Preventive Services <ul style="list-style-type: none"> • Diabetes self-management training • Digital rectal exam • EKG following welcome exam • Glaucoma screening 	\$0
Emergency and Urgent Medical Care	
Emergency Care	\$0
Emergency Care Worldwide	\$0
Urgent Care	\$0
Urgent Care Worldwide	\$0
Diagnostic Procedures*	
Diagnostic Radiology (CT scans)	\$0
Diagnostic Radiology (other than CT scans)	\$0
Diagnostic Testing and Procedures	\$0
Lab Services	\$0
Outpatient X-rays	\$0
Hearing Services	
Hearing Exam (routine)	\$0
	Coverage: one exam every twelve months
Hearing Exam (Medicare-covered)	\$0

PRIMARY BENEFITS	Your costs for in and out-of-network care
Hearing Aid Reimbursement	\$1,000 once every 36 months
Dental Services*	
Dental Services	\$0
	Medicare-covered benefits only
Vision Services	
Eye Exam (routine)	\$0
	Coverage: one exam every year
Diabetic Eye Exam	\$0
Eye Exam (Medicare-covered)	\$0
Eyewear Reimbursement	\$200 once every 24 months
Mental Health Services*	
Inpatient Mental Health Care	\$0 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Mental Health Care	\$0 (individual sessions)
	\$0 (group sessions)
Partial Hospitalization Services	\$0
Intensive Outpatient Service	\$0
Inpatient Substance Use Disorder	\$0 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Substance Use Disorder	\$0 (individual sessions)
	\$0 (group sessions)
Skilled Nursing Services*	
Skilled Nursing Facility (SNF) Care	\$0 per day, days 1-100
	Limited to 100 days per Medicare benefit period. See the <i>Schedule of Cost Sharing</i> for details on the benefit periods.
Outpatient Rehabilitation Services	
Occupational Therapy Rehabilitation Services	\$0
Physical and Speech Therapy Rehabilitation Services	\$0

PRIMARY BENEFITS	Your costs for in and out-of-network care
Ambulance* and Transportation Services	
Ambulance Services	\$0
	<p>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.</p>
Transportation (non-emergency)	Covered
	<p>Coverage: up to 24 one-way trips per year with 60 miles allowed per trip.</p>
Medicare Part B Prescription Drugs*	
Medicare Part B Prescription Drugs	\$0

***These benefits may require prior authorization.**

Medicare Part D Prescription Drugs

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section on page 9 for your plan benefits at each Part D phase, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in and out-of-network care
Acupuncture Services	\$0
	Medicare-covered benefits only
Allergy Shots	\$0
Allergy Testing	\$0
Blood	\$0
	All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	\$0
Chiropractic Services*	\$0
	Medicare-covered benefits only
Diabetic Supplies*	\$0
Durable Medical Equipment (DME)*	\$0
Home Health Agency Care*	\$0
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.
Intensive Cardiac Rehabilitation Services	\$0
Medical Supplies*	Your cost share is based upon the provider of services
Outpatient Dialysis Treatments*	\$0
Podiatry Services	\$0
	Medicare-covered benefits only
Prosthetic Devices*	\$0
Pulmonary Rehabilitation Services	\$0
Supervised Exercise Therapy (SET) for PAD	\$0
Radiation Therapy*	\$0

***These benefits may require prior authorization.**

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Fitness Program	SilverSneakers®
Resources for Living®	This program is offered to help you locate resources for everyday needs.
Routine Physical	\$0 A routine physical exam is offered once per calendar year.
Teladoc™	\$0 Telemedicine services with a Teladoc provider. State mandates may apply.
Telehealth PCP	\$0
Telehealth Specialist	\$0
Telehealth Occupational Therapy Service	\$0
Telehealth PT and ST Services	\$0
Telehealth Other Health Care Providers	\$0
Telehealth Individual Mental Health*	\$0
Telehealth Group Mental Health*	\$0
Telehealth Individual Psychiatric Services*	\$0
Telehealth Group Psychiatric Services*	\$0
Telehealth Individual Outpatient Substance Use Disorder*	\$0
Telehealth Group Outpatient Substance Use Disorder*	\$0
Telehealth Kidney Disease Education Services	\$0
Telehealth Diabetes Self-Management Training	\$0
Telehealth Opioid Treatment Program Services*	\$0
Telehealth Urgent Care	\$0
Wigs	\$0
Maximum	unlimited
Frequency	unlimited

***These benefits may require prior authorization.**

PHARMACY - PRESCRIPTION DRUG BENEFITS

Deductible **\$0**

Pharmacy Network **P1**

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website ([AetnaRetireePlans.com](https://www.aetna.com/retireeplans)).

Formulary (Drug List) **Comprehensive Plus**

INITIAL COVERAGE PHASE

This is your cost sharing until covered Medicare prescription drug expenses reach the \$2,100 annual out-of-pocket limit:

	30-day Supply through Network Retail		90-day Supply through Network Retail or Mail		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
3 Tier plan					
Tier 1 Generic drugs	You pay \$9	You pay \$10	You pay \$18	You pay \$18	You pay \$20
Tier 2 Preferred Brand drugs	You pay \$20	You pay \$20	You pay \$40	You pay \$40	You pay \$40
Tier 3 Non-Preferred Brand drugs	You pay \$35	You pay \$35	You pay \$70	You pay \$70	You pay \$70

You won't pay more than \$35 for a one-month supply or \$105 for up to a 90-day supply of each covered insulin product regardless of the cost-sharing tier.

If you reside in a long-term care facility, your cost share is the same as a 30-day supply at a retail pharmacy and you may receive up to a 31-day supply.

CATASTROPHIC COVERAGE PHASE

Catastrophic Coverage benefits start once the annual out-of-pocket threshold of \$2,100 for covered Part D prescription drugs is reached. Once you are in the Catastrophic Coverage Phase, you will stay in this payment phase until the end of the calendar year.

- During this payment phase, you pay nothing for your covered Part D drugs.
- You may have cost sharing for drugs that are covered under our Non-Part D Supplemental Benefit

REQUIREMENTS

Precertification	Applies
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Step Therapy	Applies
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NON-PART D SUPPLEMENTAL BENEFIT

- Agents used for cosmetic purposes or hair growth
 - Agents used to promote fertility
 - Agents when used for anorexia, weight loss, or weight gain
 - Agents when used for the symptomatic relief of cough and colds
 - Agents when used for the treatment of sexual or erectile dysfunction (ED)
 - Select prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
 - Other miscellaneous non-Part D drugs not otherwise described above
-

MEDICAL DISCLAIMERS

For more information about Aetna plans, go to [AetnaRetireePlans.com](https://www.aetna.com/retireeplans) or call Member Services toll-free at [1-888-267-2637](tel:1-888-267-2637) (TTY: [711](tel:711)). Hours are 8 AM to 9 PM ET, Monday through Friday.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the *Evidence of Coverage* (EOC). You can request a copy of the EOC by contacting Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY: [711](tel:711)). Hours are 8 AM to 9 PM ET, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your *Evidence of Coverage*.
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non-contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare-covered services under the plan.

PHARMACY DISCLAIMERS

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30-day supply.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call [1-866-241-0357](tel:1-866-241-0357) (TTY users should call [711](tel:711)), 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which an additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the “Non-Part D Supplemental Benefit” section in the chart above. Non-Part D drugs covered under the non-Part D supplemental drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible or annual out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

PLAN DISCLAIMERS

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

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

SilverSneakers is a registered trademark of Tivity Health, Inc. ©2025 Tivity Health, Inc. All rights reserved.

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

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call **1-800-MEDICARE** (TTY users should call **1-877-486-2048**), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

You can also visit our website at AetnaRetireePlans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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Notice of Availability (NOA)

TTY: [711](tel:711)

To access language services at no cost to you, call the number on this document. (English)

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للحصول على خدمات اللغة مجاناً، اتصل بالرقم المذكور في هذه الوثيقة. (Arabic)

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa dookumentii kanarra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro indiqué sur ce document. (French)

Pou jwenn sèvis lang san ou pa peye anyen, rele nimewo ki sou dokiman sa a. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer in diesem Dokument an. (German)

Inā ake ‘oe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ‘oe i ka helu ma kēia palapala. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj ntawm daim ntawv no. (Hmong)

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無料の言語サービスをご利用いただくには、この書類に記載されている番号にお電話ください。 (Japanese)

လၢကမၤန့ၢ် ကျိၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢကၤတၢ်တၢ်စ့ၤ လၢန့ၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီၢ်လံာ်မိအံၤ အဖီခိၣ်န့ၣ်တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພື່ອ ຄົ້ນຄວາມບໍລິການພາສາໂດຍ ບໍ່ຈ່າຍຄ່າ ຈົ່ງ ຈາຍໃດໆ, ໃຫ້ ໂທຫາ ຕົວໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

Ligue para o número indicado neste documento para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que aparece en este documento. (Spanish)

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

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)

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Annual Notice of Change for 2026

You're enrolled as a member of Aetna Medicare Plan (PPO).

This material describes changes to our plan's costs and benefits next year.

- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Schedule of Cost Sharing and Evidence of Coverage*. Get a copy at AetnaRetireePlans.com or call Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) to get a copy by mail.

More Resources

- This material is available for free in Spanish. Este material está disponible de forma gratuita en español.
- Call Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) for more information. Hours are 8 a.m. to 9 p.m. ET, Monday through Friday. This call is free.
- This material may be available in other formats such as braille, large print or other alternate formats upon request.

About Aetna Medicare Plan (PPO)

- Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Aetna Medicare. When it says “plan” or “our plan,” it means Aetna Medicare Plan (PPO).
- If you want to keep the same Aetna Medicare plan, your plan benefits administrator will give you instructions if there is any action you need to take to remain enrolled.
- You can change your coverage during your former employer/union/trust open enrollment period. Your plan benefits administrator will tell you what other plan choices might be available to you under your group retiree coverage.
- You can switch to an individual Medicare health plan or to Original Medicare; however, this would mean dropping your group retiree coverage. As a member of a group Medicare plan, you're eligible for a special enrollment period if you leave your former employer/union/trust plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time.
- Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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Annual Notice of Changes for 2026

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Deductible	No Deductible	No Deductible
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for your covered services. (See Section 1.2 for details.)	From network and out-of-network providers combined: \$0	From network and out-of-network providers combined: \$0
Primary care office visits	\$0 copay per visit	\$0 copay per visit
Specialist office visits	\$0 copay per visit	\$0 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	\$0 per stay	\$0 per stay
Part D drug coverage deductible (Go to Section 1.6 for details)	No Deductible	No Deductible
Part D drug coverage (Go to Section 1.6 for details, including yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	Standard cost-sharing (30-day supply) during the Initial Coverage Stage: <i>Generic:</i> You pay \$10 <i>Preferred Brand:</i> You pay \$20 <i>Non-Preferred Brand:</i> You pay \$35 Preferred cost-sharing (30-day supply) during the Initial Coverage Stage: <i>Generic:</i> You pay \$9 <i>Preferred Brand:</i> You pay \$20 <i>Non-Preferred Brand:</i> You pay \$35	Standard cost-sharing (30-day supply) during the Initial Coverage Stage: <i>Generic:</i> You pay \$10 <i>Preferred Brand:</i> You pay \$20 <i>Non-Preferred Brand:</i> You pay \$35 Preferred cost-sharing (30-day supply) during the Initial Coverage Stage: <i>Generic:</i> You pay \$9 <i>Preferred Brand:</i> You pay \$20 <i>Non-Preferred Brand:</i> You pay \$35

	2025 (this year)	2026 (next year)
	<p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our non-Part D supplemental benefit. 	<p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our non-Part D supplemental benefit.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Your coverage is provided through a contract with your former employer/union/trust. Your plan benefits administrator will provide you with information about your plan premium (if applicable). If Aetna bills you directly for your total plan premium, we will mail you a monthly invoice detailing your premium amount.

You must also continue to pay your Medicare Part B premium.

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 5 for more information about Extra Help from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you've paid this amount, you generally pay nothing for covered services for the rest of the calendar year.

Cost	2025 (this year)	2026 (next year)
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copayments and deductibles, if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.</p> <p>Our plan premium (if applicable) and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.</p>	<p>\$0</p>	<p>\$0</p> <p>Once you've paid \$0 out of pocket for covered services, you'll pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.</p>

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the *2026 Provider Directory* [AetnaRetireePlans.com](https://www.aetna.com/retireeplans) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at [AetnaRetireePlans.com](https://www.aetna.com/retireeplans).
- Call Member Services at **1-888-267-2637** (TTY users call **711**) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at **1-888-267-2637** (TTY users call **711**) for help.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the *2026 Pharmacy Directory* [AetnaRetireePlans.com](https://www.aetna.com/retireeplans) to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at [AetnaRetireePlans.com](https://www.aetna.com/retireeplans).
- Call Member Services at **1-888-267-2637** (TTY users call **711**) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at **1-888-267-2637** (TTY users call **711**) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

Cost	2025 (this year)	2026 (next year)
Medicare Part B drugs	Our Part B step program categories and targeted drugs may change yearly. Please visit the following link to review our list of Medicare Part B drugs that may be subject to step therapy: Aetna.com/PartB-Step . See the <i>Schedule of Cost Sharing</i> for more information.	

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically. You can find the formulary name in the 2026 *Prescription Drug Schedule of Cost Sharing*.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and you don't get this material by September 30th, call Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

We have no deductible, so this payment stage doesn't apply to you.

- **Stage 2: Initial Coverage**

In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	Because we have no deductible, this payment stage doesn't apply to you.

Drug Costs in Stage 2: Initial Coverage

Your cost sharing in the Initial Coverage Stage may be changing from a copayment to coinsurance or coinsurance to a copayment. Go to the following table for the changes from 2025 to 2026. The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to the 2026 *Prescription Drug Schedule of Cost Sharing*.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Stage 2: Initial Coverage Stage	Standard cost sharing	Standard cost sharing
<p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p> <p>You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.</p>	<i>Generic</i> <u>Retail and Mail-order:</u> You pay \$10	<i>Generic</i> <u>Retail and Mail-order:</u> You pay \$10
	<i>Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$20	<i>Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$20
	<i>Non-Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$35	<i>Non-Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$35
	Preferred cost sharing	Preferred cost sharing
	<i>Generic</i> <u>Retail and Mail-order:</u> You pay \$9	<i>Generic</i> <u>Retail and Mail-order:</u> You pay \$9
	<i>Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$20	<i>Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$20
<i>Non-Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$35	<i>Non-Preferred Brand</i> <u>Retail and Mail-order:</u> You pay \$35	

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our non-Part D supplemental benefit.

For specific information about your costs in the Catastrophic Coverage Stage, go to your 2026 *Prescription Drug Schedule of Cost Sharing*.

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Continuous glucose monitors and sensors	In 2025, Dexcom and FreeStyle Libre continuous glucose monitors and supplies are available at participating pharmacies. Your provider must obtain authorization for a continuous glucose monitor. Sensors can be obtained without prior authorization from the plan.	In 2026, Dexcom and FreeStyle Libre continuous glucose monitors and sensors are available without a prior authorization at network pharmacies with a history of insulin usage in the past 6 months. Prior authorization for monitors and sensors may apply as well as exception requests if exceeding quantity limits that align to Medicare coverage guidance.
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-888-267-2637 (TTY users call 711) or visit Medicare.gov .

SECTION 3 How to Change Plans

Your plan benefits administrator will tell you if you need to do anything to stay enrolled in your Aetna Medicare Plan.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, contact your plan benefits administrator they will let you know what options are available to you under your group retiree coverage.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Aetna Medicare Plan (PPO).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at **1-888-267-2637** (TTY users call **711**) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (**1-800-633-4227**) and ask to be disenrolled. TTY users can call **1-877-486-2048**. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [Medicare.gov](https://www.Medicare.gov), check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (**1-800-633-4227**). TTY users can call **1-877-486-2048**.
- **It is important that you carefully consider your decision before changing your coverage. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans. Call your plan benefits administrator for information.**

Section 3.1 Deadlines for Changing Plans

You may be able to change to a different plan during your former employer/union/trust open enrollment period. Our plan may allow you to make changes at other times as well. Your plan benefits administrator will let you know what other plan options may be available to you.

Section 3.2 Are there other times of the year to make a change?

As a member of a group Medicare plan, you're eligible for a special enrollment period if you leave your former employer/union/trust plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time during the year.

It is important that you carefully consider your decision before changing your coverage. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans. Call your plan benefits administrator for information.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)). TTY users can call [1-877-486-2048](tel:1-877-486-2048), 24 hours a day, 7 days a week.
 - Social Security at [1-800-772-1213](tel:1-800-772-1213) between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users can call [1-800-325-0778](tel:1-800-325-0778).
 - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** Many states have a program called the State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227))
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP for your state. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the ADAP for your state (the name and phone number for this organization is in **Appendix A** at the back of the *Evidence of Coverage*). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help**

you manage your expenses, but it doesn't save you money or lower your drug costs.

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 5 Questions?

Get Help from Aetna Medicare Plan (PPO)

- **Call Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)).**

We're available for phone calls 8 a.m. to 9 p.m. ET, Monday through Friday. Calls to these numbers are free.

- **Read your 2026 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* and *Schedule of Cost Sharing* for Aetna Medicare Plan (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services. The *Schedule of Cost Sharing* lists out-of-pocket cost share for our plan. Get the *Evidence of Coverage* and *Schedule of Cost Sharing* on our website at [AetnaRetireePlans.com](https://www.AetnaRetireePlans.com) or call Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) to ask us to mail you a copy.

- **Visit [AetnaRetireePlans.com](https://www.AetnaRetireePlans.com)**

Our website has the most up-to-date information about our provider network (*Provider Directory* /*Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state.

Call your state's SHIP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. The name and phone numbers for this organization are in **Appendix A** at the back of the *Evidence of Coverage*.

Get Help from Medicare

- **Call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227))**

You can call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)), 24 hours a day, 7 days a week. TTY users can call [1-877-486-2048](tel:1-877-486-2048).

- **Chat live with [Medicare.gov](https://www.Medicare.gov)**

You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit [Medicare.gov](https://www.medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)). TTY users can call [1-877-486-2048](tel:1-877-486-2048).

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact [1-833-220-0349](tel:1-833-220-0349) (TTY: [711](tel:711)).

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

[1-833-220-0349](tel:1-833-220-0349) (TTY: [711](tel:711))

Email: Coordinator1557@cvshealth.com

You can file a grievance in person or by mail, phone, or email. If you need help filing a grievance, the **Civil Rights Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
[1-800-368-1019](tel:1-800-368-1019), [800-537-7697](tel:800-537-7697) (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Aetna Inc.'s website: <https://www.aetna.com/medicare>

Y0001_H6399_H1610_NDN_2025

How we guard your privacy

What personal information is — and what it isn't

By “personal information,” we mean information that can be used to identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.

How we get information about you

We get information about you from many sources, including you. We also get information from your employer, other insurers, or health care providers like doctors.

When information is wrong

Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.

How we use this information

When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your OK when we do. We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work. This means we may share your information with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.

When we need your permission

There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices, which took effect October 10, 2020. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, just visit our member website or call the toll-free number on your ID card.

Notice of Availability (NOA)

TTY: 711

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

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

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

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。 (Chinese)

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

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

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

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

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

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

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

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

လၢကမၤန့ၣ် ကျီတၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢကၢၣ်တၢ်စ့ၤ လၢန့ၣ်အိၣ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ် ဖဲန ID အဖီခိၣ်န့ၣ် တက့ၢ်. (Karen)

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

ငမီၤ ဝဇၢ် ဂၢၢ်တၢ်ပၤတၢ်မၤတၢ်မၤ လၢတလိၣ်လၢကၢၣ်တၢ်စ့ၤ လၢန့ၣ်အိၣ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ် ဖဲန ID အဖီခိၣ်န့ၣ် တက့ၢ်. (Laotian)

ដើម្បីទទួលបានសេវា ភាសាឥតគិតថ្លៃ ពីអ្នកសម្របសម្រួល លេខទូរស័ព្ទ នៅលើកាតសម្រាប់អ្នក។ (Mon-Khmer, Cambodian)

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

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

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

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

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

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

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

Y0001_Y0130_H6399_2025_V1

Plan Document Notice

Did you know? Your essential plan documents are online at [AetnaRetireePlans.com](https://www.aetna.com/retireeplans). This includes your *Evidence of Coverage* (EOC), Schedule of Cost Sharing (SOC) and your plan’s formulary, too. You can access them anytime, anywhere, from any device, no matter if it’s your computer, tablet or smartphone.

Be sure you have the most up-to-date info. Your 2026 documents are currently available on our website. To view/download your documents:

Material	Where to find 2026 info	Call to request printed material
Your EOC name: ESA with RX	AetnaRetireePlans.com	1-866-325-5908 (TTY: 711)
Schedule of cost sharing (SOC)	AetnaRetireePlans.com <ul style="list-style-type: none">Once on the site, scroll down to the Review Evidence of Coverage (EOC) section and click on “View, download, or request to see the details of your 2026 benefits.”	1-866-325-5908 (TTY: 711)
Your formulary name: 2026 GRP Comprehensive Plus (3 tier) Formulary -MAPD	AetnaRetireePlans.com	1-866-325-5908 (TTY: 711)
Pharmacy directory: Your retail pharmacy network: Medicare Group Part D P1 Network	AetnaRetireePlans.com <ul style="list-style-type: none">Select “Find doctors & prescription drugs”Follow the prescription drugs section to find a network pharmacy	Call the number on your ID card
Provider directory	AetnaRetireePlans.com	Call the number on your ID card

We’re here to help

For general questions about your plan, call us at the number on your member ID card.

Get to know your plan materials

Your EOC: a guide to what’s covered

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

Your SOC: a guide to your Medical and Prescription Drug Benefits Charts

Your SOC contains the Medical and Prescription Drug Benefits Charts, which include the health care and prescription drug benefits covered under your plan.

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.

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.

Your provider directory: the key to unlocking our provider network

In your provider directory, you'll find primary care physicians, specialists such as cardiologists and podiatrists, and other providers to help you reach your best health.

Disclaimers

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. Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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Aetna Medicare Plan (PPO) Member Services

Method	Member Services – Contact Information
CALL	The number on your member ID card or 1-888-267-2637 (TTY users call 711) Calls to this number are free. Hours of operation are 8 a.m. to 9 p.m. ET, Monday through Friday Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 a.m. to 9 p.m. ET, Monday through Friday
WRITE	Aetna Medicare PO Box 7082 London, KY 40742
WEBSITE	AetnaRetireePlans.com

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Your formulary name: 2026 GRP Comprehensive Plus (3 tier) Formulary -MAPD	AetnaRetireePlans.com	1-866-325-5908 (TTY: 711)
Pharmacy directory: Your retail pharmacy network: Medicare Group Part D P1 Network	AetnaRetireePlans.com <ul style="list-style-type: none">Select “Find doctors & prescription drugs”Follow the prescription drugs section to find a network pharmacy	Call the number on your ID card
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Notice of Availability (NOA)

TTY: [711](tel:711)

To access language services at no cost to you, call the number on this document. (English)

እርስዎ ወጪ ሳያውጡ የቋንቋ አገልግሎቶችን ለመድረስ በዚህ ሰነድ ላይ ወዳለዉ ቁጥር ይደውሉ። (Amharic)

(Arabic) للحصول على خدمات اللغة مجانًا، اتصل بالرقم المذكور في هذه الوثيقة.

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

Tajaajjila afaanii bilisaan argachuuf, lakkoofsa dookumentii kanarra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro indiqué sur ce document. (French)

Pou jwenn sèvis lang san ou pa peye anyen, rele nimewo ki sou dokiman sa a. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer in diesem Dokument an. (German)

Inā ake ‘oe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ‘oe i ka helu ma kēia palapala. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj ntawm daim ntawv no. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato in questo documento. (Italian)

無料の言語サービスをご利用いただくには、この書類に記載されている番号にお電話ください。(Japanese)

လၢကမၤန့ၢ် ကျိၣ်တၢ်မၤတၢ်မၤတၢ်မၤ လၢတလိၣ်လၢၣ်ဘျီၣ်လၢၣ်စ့ၤ လၢန့ၢ်ဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီၢ်လံာ်မိအံၤအဖီၣ်န့ၣ်တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພື່ອ ຄົ້ນຄວາມບໍລິການພາສາໂດຍ ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, ໃຫ້ໂທຫາເບີໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

Ligue para o número indicado neste documento para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que aparece en este documento. (Spanish)

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

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)

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Aetna Medicare

Former Employer/Union/Trust Name: **CITY OF WILMINGTON**

Group Agreement Effective Date: **01/01/2026**

Master Plan ID: **0002497**

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 document with information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (Go to Chapter 4, Medical Benefits Chart (what's covered and what you pay).) If you have questions on how to access any of your benefits, you can call our general Member Services team at **1-888-267-2637**. (TTY users call **711**.) Hours are 8 AM to 9 PM ET, Monday through Friday. To locate a network provider visit aetna.com/search. We have also included contact information for certain benefits, where applicable, in the chart below.


Annual Deductible	FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED
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.	No Deductible
Annual Maximum Out-of-Pocket Limit	FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED
The maximum out-of-pocket limit is the most you will pay for covered Medicare Part A and B services, including any deductible (if applicable).	\$0


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 provider (PCP): <ul style="list-style-type: none"> • Family Practitioner • Internal Medicine • General Practitioner • Geriatrician • Physician Assistants (Not available in all states) • Nurse Practitioners (Not available in all states) <p>If you receive more than one covered service during the single visit.</p>	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 you receive 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.



 This apple shows preventive services in the Medical Benefits Chart.



Medical Benefits Chart



Covered Service	What you pay in-network and out-of-network
<p> Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our 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.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>
<p>Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. <p>An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. 	<p>\$0 copay for each Medicare-covered acupuncture visit.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Acupuncture for chronic low back pain <i>(continued)</i> Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>	
<p>Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be 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.</p> <p>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.</p>	<p>\$0 copay for each Medicare-covered one-way trip via ground or air ambulance.</p>
<p>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.</p> <p>Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to Medicare preventive visit. You may schedule your annual routine physical once each calendar year.</p> <p>Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. (See Outpatient diagnostic tests and therapeutic services and supplies for more information.)</p>	<p>\$0 copay for an annual routine physical exam.</p>
<p> 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. Our plan will cover the annual wellness visit once each calendar year.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However,</p> <p><i>This service is continued on the next page</i></p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>

Covered Service	What you pay in-network and out-of-network
<p> Annual wellness visit <i>(continued)</i> 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.</p>	
<p> Bone mass measurement For qualified people (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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms) Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women aged 40 and older • Clinical breast exams once every 24 months <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p> <p>\$0 copay for each diagnostic mammogram.</p>
<p>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. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$0 copay for each Medicare-covered cardiac rehabilitation service.</p> <p>\$0 copay for each Medicare-covered intensive cardiac rehabilitation service.</p>
<p> 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.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening Covered services include:</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p><i>This service is continued on the next page</i></p>	


Covered Service	What you pay in-network and out-of-network
<p> Cervical and vaginal cancer screening <i>(continued)</i></p> <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 24 months If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	
<p>Chiropractic services Covered services include:</p> <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation <p>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.</p>	\$0 copay for each Medicare-covered chiropractic visit.
<p>Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.</p> <p>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.</p>	Cost sharing for this service will vary depending on individual services provided under the course of treatment.
<p> Colorectal cancer screening The following tests are covered:</p> <ul style="list-style-type: none"> Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy.</p> <p>Diagnostic colonoscopy: \$0 copay</p> <p>Note: If a polyp is removed or a biopsy is performed during a Medicare-covered screening or diagnostic colonoscopy, the polyp removal and associated pathology will be covered at \$0 copay.</p>
<i>This service is continued on the next page</i>	


Covered Service	What you pay in-network and out-of-network
<p> Colorectal cancer screening <i>(continued)</i></p> <p>which the last screening computed tomography colonography or the last screening colonoscopy was performed.</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Twice per calendar year. • Screening Guaiac-based fecal occult blood test (gFOBT) for patients 45 years and older. Twice per calendar year. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. 	
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.</p> <p>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.</p>	<p>\$0 copay for each Medicare-covered dental care service.</p>
<p> Depression screening</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

Covered Service	What you pay in-network and out-of-network
<p> Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these 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.</p> <p>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>
<p> Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: blood glucose meter, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and meters. • 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 2 additional pairs of inserts, or one pair of depth shoes and 3 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. • Continuous glucose monitors (CGMs) are considered durable medical equipment (DME) and are subject to applicable DME cost sharing. <p>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.</p>	<p>\$0 copay for each Medicare-covered supply to monitor blood glucose.</p> <p>\$0 copay for each pair of Medicare-covered diabetic shoes and inserts.</p> <p>\$0 copay for Medicare-covered diabetes self-management training.</p>
<p>Durable medical equipment (DME) and related supplies Covered items include, but aren't 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.</p> <p>We cover all medically necessary DME covered by Original Medicare. Your provider must provide a prescription for covered DME and obtain prior authorization if required. Our plan recommends preauthorization of the service when provided by</p> <p><i>This service is continued on the next page</i></p>	<p>\$0 copay for each Medicare-covered durable medical equipment (DME) item.</p>


Covered Service	What you pay in-network and out-of-network
<p>Durable medical equipment (DME) and related supplies <i>(continued)</i> an out-of-network provider.</p> <p>In Original Medicare, there is a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the purchase price is met, you can use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up. Under certain limited circumstances we will transfer ownership of the DME item to you.</p> <p>The most recent list of participating network pharmacies and suppliers is available on our website at AetnaRetireePlans.com</p> <p>Continuous glucose monitors (CGMs) and supplies are available through participating DME providers.</p> <p>Dexcom and FreeStyle Libre continuous glucose monitors and sensors are available without a prior authorization at network pharmacies with a history of insulin usage in the past 6 months. For those not using insulin as part of their treatment plan, prior authorization will be required for monitors and sensors. Prior authorization for monitors and sensors may apply as well as exception requests if exceeding quantity limits that align to Medicare coverage guidance.</p> <p>For a list of DME providers, visit Aetna.com/dsepublicContent/assets/pdf/en/DME_National_Provider_Listing.pdf.</p> <p>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.</p>	
<p>Emergency care Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an</p>	<p>\$0 copay for emergency care.</p> <p>\$0 copay for emergency care worldwide (i.e., outside the United States).</p> <p>\$0 copay for each one-way trip via ground or air ambulance worldwide (i.e., outside the United States).</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Emergency care (<i>continued</i>) illness, injury, severe pain, or a medical condition that's quickly getting worse.</p> <p>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.</p> <p>This coverage is available worldwide (i.e., outside of the United States).</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Emergency care (worldwide) • Emergency ambulance services (worldwide) <p>You may have to pay the provider at the time of service and submit for reimbursement.</p>	
<p>Fitness program (physical fitness) You are covered for a basic membership to any SilverSneakers® participating fitness facility.</p> <p>If you do not reside near a participating facility, or prefer to exercise at home, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers.</p> <p>Included with your basic SilverSneakers membership, you will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self-help, and staying connected. These classes can be accessed online by visiting SilverSneakers.com.</p> <p>To get started, you will need your SilverSneakers ID number. Please visit SilverSneakers.com or call SilverSneakers at 1-855-627-3795 (TTY: 711) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers.</p> <p>Important: You get a basic membership at any participating SilverSneakers location. Facility amenities may vary by participating location including but not limited to hours, days and class types.</p>	<p>\$0 copay for basic health club membership/fitness classes at participating SilverSneakers locations.</p>

Covered Service	What you pay in-network and out-of-network
<p> Health and wellness education programs 24-Hour Nurse Line: You can talk to a registered nurse 24 hours a day, 7 days a week on the 24/7 Nurse Line. They can help with health-related questions when your doctor is not available. Call 1-855-493-7019 (TTY: 711). The registered nurse staff cannot diagnose, prescribe or give medical advice. If you need urgent or emergency care, call 911 and/or your doctor immediately.</p> <p>* While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics.</p> <p>Health education: You can meet with a certified health educator or other qualified health professional to learn about health and wellness topics like: diabetes management, nutrition counseling, asthma education, and more. You have the option to meet one-on-one, in a group, or virtually. Ask your provider for information on how these services may help you.</p>	<p>There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line benefit.</p> <p>\$0 copay for Health education.</p>
<p>Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Routine hearing exams: one exam every twelve months 	<p>\$0 copay for each Medicare-covered hearing exam.</p> <p>\$0 copay for each non-Medicare covered routine hearing exam.</p>
<p>Hearing services — Hearing aids This is a reimbursement benefit towards the cost of hearing aids. You may see any licensed hearing provider in the U.S. 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.</p> <p>Notes:</p> <ul style="list-style-type: none"> • If you use a non-licensed provider, you will not receive reimbursement. • You are responsible for any charges above the reimbursement amount. 	<p>Our plan will reimburse you up to \$1,000 once every 36 months towards the cost of hearing aids.</p>
<p><i>This service is continued on the next page</i></p>	



Covered Service	What you pay in-network and out-of-network
<p>Hearing services — Hearing aids <i>(continued)</i></p> <p>* Amounts you pay for hearing aids do not apply to your Out-of-Pocket Maximum.</p>	
<p> HIV screening</p> <p>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>If you are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to 3 screening exams during a pregnancy 	<p>There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Before you get 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.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • 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 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 <p>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.</p>	<p>\$0 copay for each Medicare-covered home health service.</p> <p>\$0 copay for each Medicare-covered durable medical equipment (DME) item.</p>
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person 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).</p> <p>Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan.</p> <p>Covered services include, but aren't limited to:</p>	<p>You will pay the cost sharing that applies to primary care provider services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services.</p> <p>(See Physician/Practitioner services, including doctor's office visits or Home health agency care for any applicable cost sharing.)</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Home infusion therapy <i>(continued)</i></p> <ul style="list-style-type: none"> Professional services, including nursing services, furnished in accordance with our 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 	<p>Note: Home infusion drugs, pumps, and devices provided during a home infusion therapy visit are covered separately under your Durable medical equipment (DME) and related supplies benefit.</p>
<p>Hospice care</p> <p>You're eligible for 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. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Drugs for symptom control and pain relief Short-term respite care Home care <p>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</p> <p>For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p>For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B and aren't related to your terminal prognosis, you pay your plan cost-sharing amount for these services and you must follow plan rules (like there's a requirement to get prior authorization).</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p> <p>Hospice consultations are included as part of inpatient hospital care.</p> <p>Physician service cost sharing may apply for outpatient consultations.</p>
<p><i>This service is continued on the next page</i></p>	


Covered Service	What you pay in-network and out-of-network
<p>Hospice care <i>(continued)</i></p> <p>For services covered by Aetna Medicare Plan (PPO) but not covered by Medicare Part A or B: Aetna Medicare Plan (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.</p> <p>For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4 of your <i>Evidence of Coverage</i>.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules <p>We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 of the <i>Evidence of Coverage</i> for more information.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p> <p>\$0 copay for all other vaccines covered under Medicare Part B.</p> <p>You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge.</p>	<p>For each inpatient hospital stay, you pay: \$0 per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Inpatient hospital care <i>(continued)</i></p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All components of blood are covered starting with the first pint. • Physician services <p>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're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet Medicare</p> <p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Inpatient hospital care <i>(continued)</i></p> <p>Hospital Benefits. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p> <p>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.</p>	
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge.</p> <p>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.</p>	<p>For each inpatient stay, you pay: \$0 per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p>
<p>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay</p> <p>If you've used up your skilled nursing facility benefits or if the skilled nursing facility or inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copay for Medicare-covered primary care provider (PCP) services.</p> <p>\$0 copay for Medicare-covered specialist services.</p> <p>\$0 copay for each Medicare-covered diagnostic procedure and test.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>\$0 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>\$0 copay for each Medicare-covered x-ray.</p> <p>\$0 copay for each Medicare-covered therapeutic radiology service.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay for continuous glucose monitor supplies.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay <i>(continued)</i></p> <ul style="list-style-type: none"> Physical therapy, speech therapy, and occupational therapy <p>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.</p>	<p>\$0 copay for each Medicare-covered prosthetic and orthotic device.</p> <p>\$0 copay for each Medicare-covered physical or speech therapy visit.</p> <p>\$0 copay for each Medicare-covered occupational therapy visit.</p>
<p> 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.</p> <p>We cover 3 hours of one-on-one counseling services during the first year you get 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 get 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.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p>Medicare Part B 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:</p> <ul style="list-style-type: none"> Drugs that usually aren’t self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan The Alzheimer’s drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could 	<p>\$0 copay per prescription or refill.</p> <p>\$0 copay for each chemotherapy or infusion therapy Part B drug.</p> <p>\$0 copay for the administration of the chemotherapy drug as well as for infusion therapy.</p> <p>\$0 copay for each allergy shot. You may have to pay an office visit cost share if you get other services at the same time that you get the allergy shot.</p> <p>\$0 copay for each insulin Part B drug.</p> <p>Part B drugs may be subject to Step</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Medicare Part B drugs (continued)</p> <p>add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment</p> <ul style="list-style-type: none"> • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) 	<p>Therapy requirements.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Medicare Part B drugs (continued)</p> <ul style="list-style-type: none"> • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) • Allergy shots <p>This link will take you to a list of Part B drugs that may be subject to Step Therapy: Aetna.com/partb-step.</p> <p>We also cover some vaccines under our Part B and Part D drug benefit.</p> <p>Chapter 5 of the <i>Evidence of Coverage</i> explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D drugs through our plan is explained in Chapter 6 of the <i>Evidence of Coverage</i>.</p> <p>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.</p>	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>\$0 copay for each Medicare-covered opioid use disorder treatment service.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Opioid treatment program services <i>(continued)</i> 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.</p>	
<p>Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All components of blood are covered starting with the first pint. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests <p>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.</p>	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$0 copay for each Medicare-covered x-ray.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>\$0 copay for Medicare-covered blood services.</p> <p>\$0 copay for each Medicare-covered diagnostic procedure and test.</p> <p>\$0 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>\$0 copay for each Medicare-covered CT scan.</p> <p>\$0 copay for each Medicare-covered diagnostic radiology service other than CT scan.</p> <p>\$0 copay for each Medicare-covered therapeutic radiology service.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay for continuous glucose monitor supplies.</p>
<p>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.</p>	<p>Your cost share for Observation Care is based upon the services you receive.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Outpatient hospital observation <i>(continued)</i></p> <p>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • 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 you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff.</p> <p>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.</p>	<p>\$0 copay per facility visit.</p> <p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$0 copay for emergency care.</p> <p>\$0 copay for each Medicare-covered diagnostic procedure and test.</p> <p>\$0 copay for each Medicare-covered lab service.</p> <p>\$0 copay for each Medicare-covered diagnostic radiology and complex imaging service.</p> <p>\$0 copay for each Medicare-covered x-ray.</p> <p>\$0 copay for each Medicare-covered therapeutic radiology service.</p>
<p><i>This service is continued on the next page</i></p>	



Covered Service	What you pay in-network and out-of-network
<p>Outpatient hospital services <i>(continued)</i></p>	<p>\$0 copay for each Medicare-covered individual session for outpatient psychiatrist service.</p> <p>\$0 copay for each Medicare-covered group session for outpatient psychiatrist service.</p> <p>\$0 copay for each Medicare-covered individual session for outpatient mental health service.</p> <p>\$0 copay for each Medicare-covered group session for outpatient mental health service.</p> <p>\$0 copay for each Medicare-covered partial hospitalization visit.</p> <p>\$0 copay for each Medicare-covered intensive outpatient visit.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p> <p>\$0 copay for continuous glucose monitor supplies.</p> <p>\$0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.</p>
<p>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 licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p>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.</p> <p>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.</p>	<p>\$0 copay for each Medicare-covered individual session for outpatient psychiatrist service.</p> <p>\$0 copay for each Medicare-covered group session for outpatient psychiatrist service.</p> <p>\$0 copay for each Medicare-covered individual session for outpatient mental health service.</p> <p>\$0 copay for each Medicare-covered group session for outpatient mental health service.</p>




Covered Service	What you pay in-network and out-of-network
<p>Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$0 copay for each Medicare-covered physical or speech therapy visit.</p> <p>\$0 copay for each Medicare-covered occupational therapy visit.</p>
<p>Outpatient substance use disorder 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 substance use disorder 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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change <p>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.</p>	<p>\$0 copay for each Medicare-covered individual session for outpatient substance use disorder service.</p> <p>\$0 copay for each Medicare-covered group session for outpatient substance use disorder service.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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.</p> <p>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.</p>	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$0 copay for each Medicare-covered outpatient surgery at a hospital outpatient facility.</p> <p>\$0 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center.</p>



Covered Service	What you pay in-network and out-of-network
<p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p> <p>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.</p>	<p>\$0 copay for each Medicare-covered partial hospitalization visit.</p> <p>\$0 copay for each Medicare-covered intensive outpatient visit.</p>
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically necessary medical care or surgery services you get 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: <ul style="list-style-type: none"> ◦ Primary care provider services ◦ Physician specialist services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services ◦ Occupational therapy services ◦ Physical and speech therapy services ◦ Opioid treatment services 	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided <p>\$0 copay for Medicare-covered primary care provider (PCP) services (including urgently needed services).</p> <p>\$0 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services).</p> <p>Your cost share for cancer-related treatment is based upon the services you receive.</p> <p>\$0 copay for each Medicare-covered hearing exam.</p> <p>Certain additional telehealth services,</p>
<p><i>This service is continued on the next page</i></p>	


Covered Service	What you pay in-network and out-of-network
<p>Physician/Practitioner services, including doctor’s office visits <i>(continued)</i></p> <ul style="list-style-type: none"> ◦ Outpatient substance use disorder services (individual sessions) ◦ Outpatient substance use disorder services (group sessions) ◦ Kidney disease education services ◦ Diabetes self-management services • For more details on your additional telehealth coverage, please review the Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth. <ul style="list-style-type: none"> ◦ 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 provider who offers the service by telehealth. Not all providers offer telehealth services. ◦ You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc™, MinuteClinic Video Visit, or other provider that offers telehealth services covered under your plan. Members can access Teladoc at Teladoc.com/Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711), available 24/7. Note: Teladoc is not currently available outside of the United States and its territories (Guam, Puerto Rico, and the U.S. Virgin Islands). You can find out if MinuteClinic Video Visits are available in your area at CVS.com/MinuteClinic/virtual-care/videovisit. • 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, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: 	<p>including:</p> <ul style="list-style-type: none"> • \$0 copay for each primary care provider service • \$0 copay for each physician specialist service • \$0 copay for each individual session for mental health service • \$0 copay for each group session for mental health service • \$0 copay for each individual session for psychiatric service • \$0 copay for each group session for psychiatric service • \$0 copay for each urgently needed service • \$0 copay for each occupational therapy visit • \$0 copay for each physical or speech therapy visit • \$0 copay for each opioid treatment program service • \$0 copay for each individual outpatient substance use disorder service • \$0 copay for each group outpatient substance use disorder service • \$0 copay for each kidney disease education service • \$0 copay for each diabetes self-management training service
<p><i>This service is continued on the next page</i></p>	


Covered Service	What you pay in-network and out-of-network
<p>Physician/Practitioner services, including doctor's office visits <i>(continued)</i></p> <ul style="list-style-type: none"> • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while receiving these telehealth services • Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ◦ You're not a new patient and ◦ The check-in isn't related to an office visit in the past 7 days and ◦ 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: <ul style="list-style-type: none"> ◦ You're not a new patient and ◦ The evaluation isn't related to an office visit in the past 7 days and ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Allergy testing • Diagnosis, consultation and the treatment of cancer <p>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.</p>	<p>\$0 copay for each Teladoc telehealth service.</p> <p>\$0 copay for Medicare-covered allergy testing.</p> <p>\$0 copay for nationally contracted walk-in clinics.</p>
<p>Podiatry services Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copay for each Medicare-covered podiatry visit.</p>

Covered Service	What you pay in-network and out-of-network
<p> Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening. 	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered PrEP service.</p>
<p> Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copay for each Medicare-covered digital rectal exam.</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>
<p>Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision care</i> later in this table.</p> <p>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.</p>	<p>\$0 copay for each Medicare-covered prosthetic and orthotic device.</p> <p>Your cost share for medical supplies is based upon the provider of services.</p>
<p>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.</p>	<p>\$0 copay for each Medicare-covered pulmonary rehabilitation service.</p>


Covered Service	What you pay in-network and out-of-network
<p>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. Call Resources For Living to find services in your area at 1-866-370-4842 (TTY: 711), Monday–Friday, 8 AM to 8 PM ET. A resource consultant will answer your call.</p>	<p>There is no coinsurance, copayment, or deductible for Resources For Living.</p>
<p> Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered screening for the Hepatitis C Virus.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months.</p> <p>Eligible members are people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p>
<p><i>This service is continued on the next page</i></p>	


Covered Service	What you pay in-network and out-of-network
<p> Screening for lung cancer with low dose computed tomography (LDCT) <i>(continued)</i> For LDCT lung cancer screenings after the initial LDCT screening: the members must get an 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	
<p> 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.</p> <p>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 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>
<p>Services to treat kidney disease Covered services include:</p> <ul style="list-style-type: none"> • 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 6 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 <i>Evidence of Coverage</i>, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (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) 	<p>\$0 copay for self-dialysis training.</p> <p>\$0 copay for each Medicare-covered kidney disease education session.</p> <p>\$0 copay for in- and out-of-area outpatient dialysis.</p> <p>For each inpatient hospital stay, you pay: \$0 per stay.</p> <p>Cost sharing is charged for each medically necessary covered inpatient stay.</p> <p>\$0 copay for home dialysis equipment and supplies.</p> <p>\$0 copay for Medicare-covered home support services.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p>Services to treat kidney disease <i>(continued)</i></p> <p>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.</p> <p>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.</p>	
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of skilled nursing facility care, go to Chapter 12 of the <i>Evidence of Coverage</i>. Skilled nursing facilities are sometimes called SNFs.)</p> <p>Days covered: up to 100 days per benefit period. A prior hospital stay is not required.</p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • 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 our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All components of blood are covered starting with the first pint. • 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 • Physician/Practitioner services <p>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.</p>	<p>\$0 per day, days 1-100 for each Medicare-covered SNF stay.</p> <p>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 you can have.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p><i>This service is continued on the next page</i></p>	

Covered Service	What you pay in-network and out-of-network
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) <i>(continued)</i></p> <ul style="list-style-type: none"> • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Additional (non-Medicare covered) individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year 	<p>\$0 copay for each additional non-Medicare covered smoking and tobacco use cessation visit.</p>
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training 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 <p>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.</p>	<p>\$0 copay for each Medicare-covered Supervised Exercise Therapy service.</p>
<p>Transportation services (non-emergency)</p> <p>We cover:</p> <p><i>This service is continued on the next page</i></p>	<p>\$0 copay per trip.</p>

Covered Service	What you pay in-network and out-of-network
<p>Transportation services (non-emergency) (continued)</p> <ul style="list-style-type: none"> • 24 one-way trips to and from plan-approved locations each year <p>Trips must be within 60 miles of provider location.</p> <p>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.</p> <ul style="list-style-type: none"> • Transportation services are administered through MTM Health • To arrange for transport, call 1-855-814-1699 (TTY: 711), Monday through Friday, 7 AM to 8 PM local time • You must schedule transportation service at least two business days before the appointment • You must cancel up to one business day in advance, or MTM Health will deduct the trip from the remaining number of trips available • This program doesn't support stretcher vans/ambulances 	
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.</p> <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Urgent care (worldwide) <p>You may have to pay the provider at the time of service and submit for reimbursement.</p>	<p>\$0 copay for each Medicare-covered urgent care facility visit.</p> <p>(See Physician/Practitioner services, including doctor's office visits for information about urgently needed services provided in a physician's office.)</p> <p>\$0 copay for each urgent care facility visit worldwide (i.e., outside the United States).</p>

Covered Service	What you pay in-network and out-of-network
<p> Vision care Covered services include:</p> <ul style="list-style-type: none"> • 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. • For people who are at high risk for glaucoma, we cover one glaucoma screening every 12 months. 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. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. <p>In addition to Medicare-covered benefits, we also offer:</p> <ul style="list-style-type: none"> • Non-Medicare covered eye exams: one exam every year • Follow-up diabetic eye exam 	<p>\$0 copay for each Medicare-covered eye exam. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received.</p> <p>\$0 copay for each Medicare-covered glaucoma screening.</p> <p>\$0 copay for one diabetic retinopathy screening.</p> <p>\$0 copay for each follow-up diabetic eye exam.</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses, traditional lenses, bifocals, trifocals, progressive lenses, or contact lenses. Designer frames are excluded.</p> <p>\$0 copay for each non-Medicare covered routine eye exam. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received.</p>
<p>Vision care — eyewear reimbursement (non-Medicare covered) Non-Medicare covered prescription eyewear includes:</p> <ul style="list-style-type: none"> • Contact lenses • Eyeglass prescription lenses • Eyeglass frames <p>You may see any licensed vision provider in the U.S. 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.</p> <p><i>This service is continued on the next page</i></p>	<p>Our plan will reimburse you up to: \$200 once every 24 months towards the cost of eyewear.</p> <p>You may be required to pay for services up front and submit for reimbursement.</p>

Covered Service	What you pay in-network and out-of-network
<p>Vision care — eyewear reimbursement (non-Medicare covered) (continued)</p> <p>Notes:</p> <ul style="list-style-type: none"> • If you use a non-licensed provider, you will not receive reimbursement. • You are responsible for any charges above the reimbursement amount. • Eyewear reimbursement excludes eyeglasses or contact lenses after cataract surgery. <p><i>* Amounts you pay for non-Medicare covered eyewear do not apply to your Out-of-Pocket Maximum.</i></p>	
<p> Welcome to Medicare preventive visit</p> <p>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 (or vaccines)), and referrals for other care if needed.</p> <p>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 want to schedule your Welcome to Medicare preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.</p> <p>\$0 copay for a Medicare-covered EKG screening following the Welcome to Medicare preventive visit.</p>
<p>Wigs</p> <p>This benefit is offered for hair loss as a result of chemotherapy.</p> <p>You can purchase wigs through a durable medical equipment (DME) supplier or supplier of your choice.</p> <p>Maximum allowance: unlimited Maximum allowance frequency: unlimited</p> <p>To find a DME supplier you can call the phone number on your Member ID card or visit our online directory at aetna.com/search. If you choose to use a supplier that is not in the DME network, you will need to pay out-of-pocket and submit a claim for reimbursement along with the receipt. You will only be reimbursed up to the benefit amount. You can find the reimbursement form at AetnaMedicare.com/forms.</p>	<p>\$0 copay for a wig.</p>

Note: See Chapter 4, Section 2 of the *Evidence of Coverage* for information on prior authorization rules.

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

Prescription Drug Schedule of Cost Sharing

Former Employer/Union/Trust Name: **CITY OF WILMINGTON**

Group Agreement Effective Date: **01/01/2026**

Master Plan ID: **0002497**

This *Prescription Drug Schedule of Cost Sharing* is part of the *Evidence of Coverage (EOC)* for our plan. When the EOC refers to the document with information on Medicare Part D prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart. (See Chapter 5, *Using plan coverage for Part D drugs* and Chapter 6, *What you pay for Part D drugs*.)

Annual Deductible Amount:	\$0
Formulary Type:	Comprehensive Plus
Number of Cost-Share Tiers:	3 Tier
Annual Out-of-Pocket Limit:	\$2,100
Retail Pharmacy Network:	P1
<p>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.</p> <p>For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call the number on your ID card, or consult the online pharmacy directory at AetnaRetireePlans.com.</p>	

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

- Tier One – Generic drugs
- Tier Two – Preferred brand drugs
- Tier Three – Non-preferred brand drugs

To find out which cost-sharing tier your drug is in, look it up in our 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*.

Important Message About What You Pay for Vaccines — Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Initial Coverage Stage: In this stage, you pay your share of covered Part D drug costs until you reach the \$2,100 annual out-of-pocket limit.

Standard Cost Share: The chart below lists the amount that 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 Generic drugs	You pay \$10	You pay \$10	You pay \$10	You pay \$20	You pay \$18
Tier 2 Preferred Brand drugs	You pay \$20	You pay \$20	You pay \$20	You pay \$40	You pay \$40
Tier 3 Non-Preferred Brand drugs	You pay \$35	You pay \$35	You pay \$35	You pay \$70	You pay \$70

You won't pay more than \$35 for a one-month supply or \$105 for up to a 90-day supply of each covered insulin product regardless of the cost-sharing tier.

*Out-of-network coverage is limited to certain situations. Go to the *Evidence of Coverage* Chapter 5, Section 2.4 (*Using a pharmacy that's not in our plan's network*) for more information.

Preferred Cost Share: The chart below lists the amount that 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 Generic drugs	You pay \$9	You pay \$10	You pay \$10	You pay \$18	You pay \$18
Tier 2 Preferred Brand drugs	You pay \$20	You pay \$20	You pay \$20	You pay \$40	You pay \$40
Tier 3 Non-Preferred Brand drugs	You pay \$35	You pay \$35	You pay \$35	You pay \$70	You pay \$70

You won't pay more than \$35 for a one-month supply or \$105 for up to a 90-day supply of each covered insulin product regardless of the cost-sharing tier.

*Out-of-network coverage is limited to certain situations. Go to the *Evidence of Coverage* Chapter 5, Section 2.4 (*Using a pharmacy that's not in our plan's network*) for more information.

Catastrophic Coverage Stage: You enter the Catastrophic Coverage Stage when you reach the \$2,100 annual out-of-pocket limit and you will remain in this stage for the rest of the plan year.

During this payment stage, you pay nothing for your covered Part D drugs. For excluded drugs covered under our Non-Part D Supplemental Benefit, the benefit information is below.

Step Therapy

Your plan includes step therapy. This requirement encourages you to try less costly but just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, the plan will then cover Drug B. Our plan's step therapy criteria can be obtained by calling Member Services at [1-888-267-2637](tel:1-888-267-2637) (TTY users call [711](tel:711)) or on our website ([AetnaRetireePlans.com](https://www.aetna.com/retireeplans)) with your formulary information.

This Plan Uses the Comprehensive Plus Formulary:

Your plan uses the Comprehensive Plus formulary, which means you have coverage for every drug identified by Medicare as a Part D drug, as long as the drug is medically necessary, and the plan rules are followed. Non-preferred copay levels apply to some drugs on the Drug List. Review the *Aetna Medicare 2026 Group Formulary (List of Covered Drugs)* for more information.

Non-Part D Supplemental Benefit

Your former employer/union/trust has purchased additional coverage for some prescription drugs not normally covered in a Medicare prescription drug plan, including the following:

- Drugs when used for the relief of cough or cold symptoms
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for weight loss
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Drugs when used for the treatment of erectile dysfunction
- Other miscellaneous non-Part D drugs not otherwise described above

The cost share for these drugs throughout all drug payment stages is listed in the Initial Coverage Stage table above. See Tier 1 for the generic cost share amount and Tier 2 for the brand cost share amount.

The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving "Extra Help" from Medicare to pay for your prescriptions, the "Extra Help" will not pay for these drugs.

To find the drugs that are covered under this supplemental benefit, go online to:

[AetnaMedicare.com/SupplementalBenefitMAPD](https://www.aetna.com/medicare/supplementalbenefitmapd). This document will also show limitations, such as quantity limits and prior authorization requirements. For more information, call Member Services.

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

Notice of Availability (NOA)

TTY: 711

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

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

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

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。 (Chinese)

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

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

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

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

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

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

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

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

လၢကမၤန့ၣ် ကျိၣ်တၢ် မၤစၢၤတၢ် မၤလၢတၢ်လိၣ်လၢကံၤန့ၣ်လၢကံၤစ့ၤ လၢန့ၣ်ဂီၤ အဂီၢ်, ကိၣ်နီၣ်ဂံၢ် လၢအအိၣ် ဖဲန ID အဖီခိၣ်န့ၣ် တက့ၢ်. (Karen)

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

ຮູ້ໄພ ອະໄຫວ ຖຽກການບໍລິການພາສາໂດຍບ ເສຍຄ່າ ວິຊາ າຍໃດໆແກ່ ທ່ານ, ໃຫ້ ໂທຫາ ບີ ທີ່ ະໃນ ບັດປະ ຈາ ຕົວຂອງທ. (Laotian)

ដើម្បីទទួលបានសេវា ឥតគិតថ្លៃ ពីអ្នកសម្របសម្រួល លេខខ្មែរ លេខ លើ គ្រឹះស្ថាន លំខ នរបស់អ្នក។ (Mon-Khmer, Cambodian)

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

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

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

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

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

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

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

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Aetna Medicare Plan (PPO) Member Services

Method	Member Services – Contact Information
Call	The number on your member ID card or 1-888-267-2637 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. Member Services 1-888-267-2637 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday
Write	Aetna Medicare PO Box 14089 Lexington, KY 40512
Website	AetnaRetireePlans.com

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **Appendix A** at the back of your *Evidence of Coverage* booklet.

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