PO Box 30017
Pittsburgh, PA 15222-0330

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Plan Sample A Request
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Do not mail
Anytown, 00 99999-8165

Important information about changes to your Aetna Employer Group Medicare Plan

Plan Document Notice

Did you know? Your essential plan documents are online at AetnaRetireePlans.com. This includes your Evidence of Coverage (EOC) and your plan's formulary, too. 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 2022 documents are currently available on our website. To view/download your documents:

Material	Where to find 2022 info	Call to request printed material
Your EOC name ESA with RX	AetnaRetireePlans.com	Call 1-866-325-5908 (TTY: 711)
Your Formulary name 2022 GRP B2 Plus (4 Tier) Formulary - MAPD	AetnaRetireePlans.com	Call 1-866-325-5908 (TTY: 711)
Pharmacy directory	AetnaRetireePlans.com	Call the number on your ID card
Provider directory	AetnaRetireePlans.com	Call the number on your ID card

Save time when you search online

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

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

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

Prefer larger text?

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

We're here to help

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

Over →

Get to know your plan materials

Your EOC: a guide to what's covered
Your EOC is a description of coverage under your Medicare plan. It also outlines how to get services and your member rights.

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

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 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.

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

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

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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

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Aetna Medicare Plan (PPO) offered by Aetna Medicare

Annual Notice of Changes for 2022

You are currently enrolled as a member of Aetna Medicare Plan (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: February 29, 2024)
GRP_ANOC_2022_D2M_25482-2_28395-5_25483-4_28399-1
Master Plan ID: 0000836, 0000840, 0000844, 0000871, 0000875

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices – Your coverage is offered through your former employer/union/trust

   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.

☐ Contact your plan benefits administrator to see if there are other options available.

☐ Check coverage and costs of individual Medicare health plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 to learn more about your choices.

3. **CHOOSE:** Decide whether you want to change your plan

   - 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's 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 are eligible for a special enrollment period if you leave your former employer/union/trust's plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time. Look in Section 2.2 to learn more about your choices.

4. **ENROLL:** To change plans, call your plan benefits administrator for information

Additional Resources

- This document is available for free in Spanish.
- Este documento está disponible sin cargo en español.
- Please contact our Member Services at the telephone number on your member ID card or call our general Member Services at 1-888-267-2637 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 9 p.m. ET, Monday through Friday.
- This document may be available in other formats such as braille, large print or other alternate formats. Please contact Member Services for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aetna Medicare Plan (PPO)

- Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Aetna Medicare. When it says "plan" or "our plan," it means Aetna Medicare Plan (PPO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Aetna Medicare Plan (PPO) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at AetnaRetireePlans.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Deductible	**$300**	**$300**
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network and out-of-network providers combined: **$3,400**	From network and out-of-network providers combined: **$3,400**
Doctor office visits	Primary care visits: **$5** copay per visit. Specialist visits: **$25** copay per visit.	Primary care visits: **$5** copay per visit. Specialist visits: **$25** 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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**$0 per stay**	**$0 per stay**

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: **No Deductible** Standard retail cost sharing for a 30-day supply during the Initial Coverage Stage: **Generic:** You pay $10 **Preferred Brand:** You pay $30 **Non-Preferred Brand:** You pay $45 **Specialty:** You pay $75	Deductible: **No Deductible** Standard retail cost sharing for a 30-day supply during the Initial Coverage Stage: **Generic:** You pay $10 **Preferred Brand:** You pay $30 **Non-Preferred Brand:** You pay $45 **Specialty:** You pay $75

Annual Notice of Changes for 2022

Table of Contents

SECTION 1 Changes to Benefits and 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.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

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

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. These limits are called the “maximum out-of-pocket amounts.” Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles, if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) and your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	**$3,400**	**$3,400** Once you have paid $3,400 out-of-pocket for covered services, you will pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

There are changes to our network of providers for next year.

An updated *Provider Directory* is located on our website at AetnaRetireePlans.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with

you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may 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 network pharmacies for some drugs. The *Prescription Drug Schedule of Cost Sharing* lists the name of your network and whether or not the network includes pharmacies with preferred cost sharing. Please refer to this network name when looking for 2022 network pharmacies. The *Prescription Drug Schedule of Cost Sharing* is enclosed in this packet.

There are changes to our network of pharmacies for next year. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network.** An updated *Pharmacy Directory* is located on our website at AetnaRetireePlans.com. You may also call Member Services for updated pharmacy information or to ask us to mail you a *Pharmacy Directory*.

Section 1.5 Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see the *2022 Schedule of Cost Sharing* included in this package.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- 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

Cost	2021 (this year)	2022 (next year)
Hearing aid reimbursement	$2,000 once every 36 months	$3,000 once every 36 months
Home infusion therapy professional services	You pay a $25 copay for each Medicare-covered service.	You pay a $0 copay for each Medicare-covered service performed by a home health care provider. You pay a $5 copay for each Medicare-covered service performed by a primary care physician. You pay a $25 copay for each Medicare-covered service performed by a specialist.
Over-the-Counter (OTC) items	Over-the-counter items are not covered.	$30 every 3 months
Telehealth additional services - physician specialist	Additional telehealth services were covered during the public health emergency.	You pay a $25 copay for each additional telehealth specialist service.

Section 1.6 Changes to Part D Prescription 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.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your**

drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- You and your doctor can ask the plan to make an exception for you and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* which is located on our website at AetnaRetireePlans.com. Look for Chapter 9, Section 6 (*Your Part D prescription drugs: How to ask for a coverage decision or make an appeal)*.

Transition applies to all Part D prescription medications not included on the formulary, or that are on our formulary but with a restriction, such as prior authorization or step therapy. A transition supply will be provided to you at the point-of-sale with exceptions where certain drugs require coverage determination whether it should be covered under Medicare Part B or Part D benefit. In such case, it might require your doctor or pharmacy to provide additional information; therefore, the issue may not be resolved at point-of-sale.

- If you are a currently enrolled member who does not request an exception before January 1, 2022, and your current Part D eligible drug therapy coverage is negatively impacted by a formulary change, we will cover up to a 30-day temporary supply of the drug starting on January 1st.

- If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with temporary coverage (up to a 30-day supply) for the applicable drug(s).

Regardless of the reason you received a temporary supply, you will need to utilize our exception process if you need to continue on the current drug.

Important Note: Please take action on working with your doctor to find appropriate alternatives or to file your exception requests before January 1st. It will make for a very easy transition into the next calendar year. To learn what you must do to ask for an exception, see the *Evidence of Coverage* which is located on our website at AetnaRetireePlans.com. Look for Chapter 9 of the *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" if you haven't received this insert by September 30, 2021, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages –

the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in the enclosed *Prescription Drug Schedule of Cost Sharing*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Your cost sharing in the initial coverage stage may be changing from copayment to coinsurance *or* coinsurance to copayment. Please see the following chart for the changes from 2021 to 2022.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard or preferred cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in the *2022 Prescription Drug Schedule of Cost Sharing* included in this packet. 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.	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** Generic: You pay $10 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $45 Specialty: You pay $75 **Preferred cost sharing** Generic: You pay $9 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $45 Specialty: You pay $75 Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** Generic: You pay $10 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $45 Specialty: You pay $75 **Preferred cost sharing** Generic: You pay $9 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $45 Specialty: You pay $75 Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages
The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

For information about your costs in these stages, look in the 2022 *Prescription Drug Schedule of Cost Sharing* included in this packet.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 If you want to stay in Aetna Medicare Plan (PPO)

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

Section 2.2 If you want to change plans

We hope to keep you as a member. However, if you want to change your plan, here are your options:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely. Your plan benefits administrator will let you know what options are available to you under your group retiree coverage.
- You can switch to an individual Medicare health plan.
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

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.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Aetna Medicare Plan (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Aetna Medicare Plan (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

You may be able to change to a different plan during your former employer/union/trust's open enrollment period. Your 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.

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

As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your former employer/union/trust's 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 Programs That Offer Free Counseling about Medicare

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

SHIP is independent (not connected with any insurance company or health plan). It is a state

program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIP at the phone number in **Addendum A** at the back of the *Evidence of Coverage*.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **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 (the name and phone numbers for this organization are in **Addendum A** at the back of the *Evidence of Coverage*).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP for your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP for your state (the name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage*).

SECTION 6 Questions?

Section 6.1 Getting Help from Aetna Medicare Plan (PPO)

Questions? We're here to help. Please call Member Services at the telephone number on your member ID card or call our general Member Services at 1-888-267-2637. (TTY only, call 711.) We are available for phone calls 8 a.m. to 9 p.m. ET, Monday through Friday. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)
This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* and the *Schedule of Cost Sharing* for Aetna Medicare Plan (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at AetnaRetireePlans.com. The *Schedule of Cost Sharing* lists the out-of-pocket cost share for your plan; a copy is included in this envelope. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website
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).

Section 6.2 Getting Help from Medicare

To get information directly from Medicare:

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

Visit the Medicare Website
You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*
You can read the *Medicare & You 2022* 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.

See the *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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

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

Aetna Medicare's pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, and Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. 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 (TTY: 711) or consult the online pharmacy directory at www.AetnaRetireePlans.com.

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

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

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

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

Schedule of Cost Sharing

Aetna Medicare

Former Employer/Union/Trust Name: **STATE OF MAINE**
Group Agreement Effective Date: **01/01/2022**
Master Plan ID: **0000836, 0000840, 0000844, 0000871, 0000875**

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. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.) If you have questions, please call our Member Services at the telephone number printed on your member ID card or call our general Member Services at 1-888-267-2637. (TTY users should call 711.) Hours are 8 AM to 9 PM ET, Monday through Friday.

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	**$300 deductible** Deductible waived for Preventive Services, Part B Drugs, Diabetic Supplies, Emergency Room Visits, Emergency Ambulance, Urgent Care, applicable Riders and Renal Care and Temporomandibular Joint Dysfunction
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).	**$3,400**

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

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

Medical Benefits Chart

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

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security	You pay a $25 copay for each Medicare-covered acupuncture visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Act (the Act) may furnish acupuncture in accordance with applicable state requirements. 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: • a masters 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. 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.	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required **Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered one-way trip via ground or air ambulance.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" preventive visit. You may schedule your annual routine physical once each calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. Please see "**Outpatient diagnostic tests and therapeutic services and supplies**" for more information.	You pay a $0 copay for an annual routine physical exam.
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. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms. You pay a $0 copay for each diagnostic mammogram.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay a $20 copay for each Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover manual manipulation of the spine to correct subluxation **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered chiropractic visit.
Chiropractic services (additional) In addition to the chiropractic service described above, we cover additional services you receive from a licensed chiropractor. We cover unlimited visits each calendar year with a licensed chiropractor for additional services.	You pay a $20 copay for each visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months Two of the following per calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. You pay a $0 copay for each Medicare-covered barium enema. If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology will be covered at $0 copay as these procedures were performed during a preventive service. If you have had polyps removed during a previous colonoscopy or have a condition that is monitored via colonoscopy (such as a prior history of colon cancer), ongoing colonoscopies are considered diagnostic, are not considered preventive screenings, and are subject to the outpatient surgery cost-sharing. (See **"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"** for more information.)

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Compression stockings Compression garments are usually made of elastic material, and are used to promote venous or lymphatic circulation. Compression garments worn on the legs can help prevent deep vein thrombosis and reduce edema, and are useful in a variety of peripheral vascular conditions.	You pay a $0 copay per pair.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover: • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered (non-routine) dental care service.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • Urine test strips Note: Continuous Glucose Monitors (CGMs) are	You pay a $0 copay for each Medicare-covered supply to monitor blood glucose. You pay a $0 copay for each pair of Medicare-covered diabetic shoes and inserts. You pay a $0 copay for Medicare-covered diabetes self-management training. You pay a $0 copay for urine test strips.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
considered Durable Medical Equipment (DME) and are subject to applicable DME cost-sharing. **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.**	
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at: AetnaRetireePlans.com. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered durable medical equipment item.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Durable medical equipment (DME) and related supplies - Foot orthotics Your plan covers foot orthotics. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for foot orthotics.
Durable medical equipment (DME) and related supplies - Wigs Your plan covers wigs for hair loss due to chemotherapy. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for a wig.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. This coverage is available worldwide (i.e., outside of the United States).	You pay a $75 copay for each emergency room visit. If you are immediately admitted to the hospital, your cost-sharing amount for the emergency room visit will be waived.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Fitness program You are covered for a basic membership to a SilverSneakers® participating fitness facility. At-home fitness kits and online classes are also available for members who do not reside near a participating club or prefer to exercise at home. Members may order one fitness kit per year through SilverSneakers. Call SilverSneakers at **1-888-423-4632** for assistance. (For TTY/TDD assistance, please dial 711.) Visit Silversneakers.com to find a participating location near you.	You pay a $0 copay for health club membership/fitness classes.
Health and wellness education programs • **24-Hour Nurse Line:** Talk to a registered nurse 24 hours a day, 7 days a week. Call us at **1-855-493-7019** (For TTY/TDD assistance, please dial 711.) • **Telemonitoring:** If you are diagnosed with congestive heart failure (CHF) and meet additional clinical criteria, such as a recent CHF-related hospital stay, you may be eligible to participate in a program to help manage your CHF. Eligible members will be contacted by an Aetna care team member. Eligible members who agree to participate in the remote monitoring program and adhere to the care management requirements will receive telemonitoring equipment. This will help to monitor your weight and blood pressure on a regular basis. Your Aetna care team will receive this information	There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line benefit. Telemonitoring is included in your plan. Written health education materials are included in your plan.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
to help you and your doctor manage your CHF. • **Written health education materials:** Members are eligible to receive the health education supplemental benefit to support a healthier lifestyle. This benefit gives members the opportunity to interact as a group, one-on-one, or virtually, with a certified health educator or other qualified health professional. Members may receive educational supplies such as books and pamphlets to augment their interactive sessions. In addition, members will be encouraged to adopt healthy habits and build skills to enhance self-care capabilities.	
Healthy Rewards The Aetna Healthy Rewards program is a highly personalized incentive and rewards program. Plan members can earn rewards in the form of merchandise gift cards by completing specific health and wellness activities within the plan year. Coinsurance, copayment, or deductible may apply to the medical service completed in order to earn the reward. There is no out-of-pocket cost to the member to redeem the reward once the required activity is complete.	Included in your plan.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. In addition to Medicare-covered benefits, we also offer: • Routine hearing exams: one every twelve months	You pay a $25 copay for each Medicare-covered hearing exam. You pay a $0 copay for each non-Medicare covered hearing exam.
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. **Notes:** • If you use a non-licensed provider you will not receive reimbursement. • You are responsible for any charges above the reimbursement amount. ***** *Amounts you pay for hearing aids do not apply to your Out-of-Pocket Maximum.*	Our plan will reimburse you up to $3,000 once every 36 months towards the cost of hearing aids.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered home health visit. You pay a $0 copay for each Medicare-covered durable medical equipment item.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan. Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You will pay the cost-sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. See **"Physician/Practitioner Services, Including Doctor's Office Visits"** or **"Home Health Agency Care"** for any applicable cost-sharing. Please note that 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.
Hospice care You may receive care from any Medicare-certified hospice program. You are 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. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:	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. Hospice consultations are included as part of inpatient hospital care. Physician service cost-sharing may apply for outpatient consultations.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, you pay your plan cost-sharing amount for these services. For services that are covered by our plan but are not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice)* of your *Evidence of Coverage*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. You pay a $0 copay for other Medicare-covered Part B vaccines. You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. 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. Covered services include but are not limited to: • Semi-private room (or a private room if medically	For each inpatient hospital stay, you pay: $0 per stay. Cost-sharing is charged for each medically necessary covered inpatient stay.

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

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Inpatient mental health care Covered services include mental health care services that require a hospital stay. 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. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	For each inpatient stay, you pay: $0 per stay. Cost-sharing is charged for each medically necessary covered inpatient stay.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your skilled nursing facility (SNF) benefits or if the SNF or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of	You pay a $5 copay for each Medicare-covered primary care doctor visit. You pay a $25 copay for each Medicare-covered specialist visit. You pay a $0 copay for each Medicare-covered diagnostic procedure and test. You pay a $0 copay for each Medicare-covered lab service. You pay a $5 copay for each Medicare-covered X-ray. You pay a $50 copay for each Medicare-covered diagnostic radiology and complex imaging service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered therapeutic radiology service. You pay a $5 copay for Medicare-covered medical supply items received from a PCP. You pay a $25 copay for Medicare-covered medical supply items received from other providers. You pay a $0 copay for each Medicare-covered prosthetic and orthotic item. You pay a $0 copay for each Medicare-covered durable medical equipment item. You pay a $20 copay for each Medicare-covered physical, speech, or occupational therapy visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Meal benefit After discharge from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to your home, you may be eligible to receive up to 14 home-delivered meals over a 7-day period delivered to your home. After our plan confirms that this benefit will help support your recovery or manage your health conditions, and is not based solely on convenience or comfort purposes, you will be contacted to schedule delivery. Note: Observation stays do not qualify you for this benefit.	You pay a $0 copay for covered meals.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea	You pay a $0 copay per prescription or refill. You pay a $0 copay for each chemotherapy or infusion therapy Part B drug. You pay a $25 copay for the administration of the chemotherapy drug as well as for infusion therapy. Part B drugs may be subject to step therapy requirements.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: Aetna.com/partb-step. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 of the *Evidence of Coverage*. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • 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 **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered opioid use disorder treatment service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost-share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed You pay a $5 copay for each Medicare-covered X-ray. You pay a $50 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $0 copay for each Medicare-covered lab service. You pay a $0 copay for each Medicare-covered diagnostic procedure and test. You pay a $0 copay for each Medicare-covered therapeutic radiology service. You pay a $5 copay for Medicare-covered medical supply items received from a PCP. You pay a $25 copay for Medicare-covered medical supply items

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	received from other providers.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Your cost share for Observation Care is based upon the services you receive.
Outpatient hospital services We cover medically-necessary services you get in the	Your cost-share is based on:

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	• 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 You pay a $50 copay per facility visit. You pay a $0 copay for each Medicare-covered lab service. You pay a $0 copay for each Medicare-covered diagnostic procedure and test. You pay a $0 copay for each Medicare-covered mental health service (individual session). You pay a $0 copay for each Medicare-covered mental health service (group session). You pay a $5 copay for each Medicare-covered X-ray. You pay a $50 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $0 copay for each

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	Medicare-covered therapeutic radiology service. You pay a $0 copay for each Medicare-covered partial hospitalization visit. You pay a $5 copay for Medicare-covered medical supply items received from a PCP. You pay a $25 copay for Medicare-covered medical supply items received from other providers. You pay a $0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself. You pay a $75 copay for each emergency room visit. If you are immediately admitted to the hospital, your cost-sharing amount for the emergency room visit will be waived.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. We also cover some telehealth visits with psychiatric and mental health professionals. See **"Physician/Practitioner services, including doctor's office visits**" for information about telehealth outpatient mental health care. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered mental health service (individual session). You pay a $0 copay for each Medicare-covered mental health service (group session).

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered physical, speech, or occupational therapy visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Outpatient substance abuse services Our coverage is the same as Original Medicare, which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered individual outpatient substance abuse session. You pay a $0 copay for each Medicare-covered group outpatient substance abuse session.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost-share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed You pay a $50 copay for each Medicare-covered outpatient surgery at a hospital outpatient facility. You pay a $50 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center.
Over-the-counter mail order drugs This plan comes with a quarterly allowance for over-the-counter (OTC) medications and supplies. For a complete list of covered items, please refer to the OTC catalog. You may place up to three orders each quarter and are limited to up to nine (9) like items per quarter (every three months), with the exception of Blood Pressure Monitors, which are limited to one per year. Orders cannot exceed your quarterly allowance. Any unused allowance will not be rolled over into the following quarter. Items may be ordered over the phone at 1-833-331-1573 (TTY: 711) Monday-Friday 9 am-8 pm local time (except Hawaii) or online at cvs.com/otchs/myorder to be	$30 every 3 months

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
shipped to your home. You can place an order online 24 hours a day, 7 days a week (24/7). Ordered items are for enrollee only. **Notes:** • You cannot pay out-of-pocket for the difference above your allowance. • The OTC limits apply to in-store/retail transactions, where available. • Reimbursements are not allowed for this benefit. Items purchased outside of the benefit are not covered or reimbursable. Members cannot mail in their OTC order to Member Services. • Quantity limits may apply to select items.	
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered partial hospitalization visit.
Physician/Practitioner services, including doctor's office visits Covered services include:	Your cost-share is based on: • the tests, services, and supplies you receive • the provider of the tests, services,

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: ◦ Primary care physician services ◦ Physician specialist services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services • This coverage is in addition to the telehealth services described below. For more details on your additional telehealth coverage, please review the Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. ◦ Members should contact their 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	and supplies • the setting where the tests, services, and supplies are performed You pay a $5 copay for each Medicare-covered primary care doctor visit (including telehealth services and urgently needed services). You pay a $25 copay for each Medicare-covered specialist visit (including surgery second opinion, telehealth services, home infusion professional services, and urgently needed services). You pay a $25 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including those for: • You pay a $5 copay for each primary care physician service • You pay a $25 copay for each physician specialist service • You pay a $0 copay for each mental health service (individual sessions) • You pay a $0 copay for each

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Video Visit, or other provider that offers telehealth services covered under your plan. ◦ Members can find out if MinuteClinic Video Visits are available in their area at CVS.com/MinuteClinic/virtual-care/videovisit. ◦ Your plan also allows you to schedule a telehealth visit 24/7 through Teladoc, a national network of virtual only U.S. board-certified family practitioners, PCPs, pediatricians, and internists to diagnose, recommend treatment, and write short-term (non-DEA) prescriptions, when necessary. ▪ Call 1-855-835-2362 (available 24/7), visit Teladoc.com, or access the Teladoc Member mobile app ▪ Notes: ◦ Currently not available outside of the United States and its territories (Guam, Puerto Rico, and the U.S. Virgin Islands) ◦ State restrictions are subject to change • 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	mental health service (group sessions) • You pay a $0 copay for each psychiatric service (individual sessions) • You pay a $0 copay for each psychiatric service (group sessions) • You pay a $20 copay for each urgently needed service You pay a $5 copay for each Teladoc service. You pay a $25 copay for each Medicare-covered (non-routine) dental care service. You pay a $0 copay for Medicare-covered allergy testing. You pay a $5 copay for nationally contracted walk-in clinics.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ 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**: ◦ 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 • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing **Prior authorization rules may apply for network services. Your network provider is responsible for**	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	You pay a $25 copay for each Medicare-covered podiatry service.
Podiatry services (additional) The reduction of nails, including mycotic nails, and the removal of corns and calluses. In addition to Medicare-covered benefits, we also offer: • Additional non-Medicare covered podiatry services: unlimited visits per year	You pay a $20 copay for each non-Medicare covered podiatry service.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. You pay a $0 copay for each Medicare covered digital rectal exam.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "**Vision Care**" later in this section for more detail. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered prosthetic and orthotic item.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay a $20 copay for each Medicare-covered pulmonary rehabilitation visit.
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 at **1-866-370-4842**.	There is no coinsurance, copayment, or deductible for Resources for Living.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
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. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "**Medicare Part B prescription drugs**." **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**	You pay a $0 copay for self-dialysis training. You pay a $0 copay for kidney disease education services. You pay a $0 copay for in- and out-of-area outpatient dialysis. See "**Inpatient hospital care**" for more information on inpatient services. You pay a $0 copay for home dialysis equipment and supplies. You pay a $0 copay for Medicare-covered home support services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
out-of-network provider.	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") Days covered: We cover 100 days per benefit period. A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services **Prior authorization rules may apply for network**	You pay $0 per day, days 1-100 for each Medicare-covered SNF stay. 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.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits. In addition to Medicare-covered benefits, we also offer: • Additional individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. You pay a $0 copay for each non-Medicare covered smoking and tobacco use cessation visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	You pay a $20 copay for each Medicare-covered supervised exercise therapy session.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Temporomandibular Joint Dysfunction (TMJ) Coverage is provided for the treatment of a specific organic condition of or physical trauma to the temporomandibular joint (jaw hinge). Coverage is limited to surgery or injections of the temporomandibular joint, physical therapy, or other medical treatments. Coverage is not provided for any procedure or device that alters the vertical relationship of the teeth or the relation of the mandible to the maxilla. Coverage for oral appliances is included. Dental services related to TMJ are not covered. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each visit.
Transportation services (non-emergency transportation) We cover: • 24 one-way trips to and from plan-approved locations each year Trips must be within 60 miles of provider location. 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.	You pay a $0 copay per trip.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Transportation services are administered through Access2Care • To arrange for transport, call **1-855-814-1699**, Monday through Friday, from 8 AM to 8 PM, in all time zones. (For TTY/TDD assistance please dial 711.) • You must schedule transportation service at least 72 hours before the appointment • You must cancel more than two hours in advance, or Access2Care will deduct the trip from the remaining number of trips available • This program doesn't support stretcher vans/ambulances • The driver's role is limited to helping the member in and out of the vehicle	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Coverage is available worldwide (i.e., outside of the United States).	You pay a $20 copay for each urgent care facility visit. Cost-sharing is not waived if you are admitted to the hospital. You pay a $20 copay for each urgent care telehealth service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will 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 two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) In addition to Medicare-covered benefits, we also offer: • Non-Medicare covered eye exams: one exam every year • Follow up diabetic eye exam	You pay a $25 copay for exams to diagnose and treat diseases and conditions of the eye. You pay a $0 copay for each Medicare-covered glaucoma screening. You pay a $0 copay for one diabetic retinopathy screening. You pay a $0 copay for each follow up diabetic eye exam. You pay a $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals. You pay a $0 copay for each non-Medicare covered eye exam. Additional cost-sharing may apply if you receive additional services during your visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
“Welcome to Medicare” preventive visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit. You pay a $0 copay for a Medicare-covered EKG screening following the "Welcome to Medicare" preventive visit.

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

Prescription Drug Schedule of Cost Sharing

Former Employer/Union/Trust Name: **STATE OF MAINE**
Group Agreement Effective Date: **01/01/2022**
Group/Account Number: **0000836, 0000840, 0000844, 0000871, 0000875**

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 the plan's coverage for your Part D prescription drugs* and Chapter 6, *What you pay for your Part D prescription drugs*.)

Annual Deductible Amount:	$0
Formulary Type:	GRP B2 Plus
Number of Cost Share Tiers:	4 Tier
Initial Coverage Limit:	$4,430
True Out-of-Pocket Amount:	$7,050
Retail Pharmacy Network:	P1

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

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

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

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

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

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

Initial Coverage Stage: Amount you pay, up to $4,430 in total covered prescription drug expenses.

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 $10	You pay $9
Tier 2 Preferred brand drugs	You pay $30	You pay $30	You pay $30	You pay $30	You pay $30
Tier 3 Non-preferred brand drugs	You pay $45	You pay $45	You pay $45	You pay $45	You pay $45
Tier 4 Specialty drugs - Includes high-cost/unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations. See the *Evidence of Coverage* Chapter 5, Section 2.5 (*Using the plan's coverage for your Part D prescription drugs, When can you use a pharmacy that is not in the plan's network?)* for 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 $9	You pay $9
Tier 2 Preferred brand drugs	You pay $30	You pay $30	You pay $30	You pay $30	You pay $30
Tier 3 Non-preferred brand drugs	You pay $45	You pay $45	You pay $45	You pay $45	You pay $45
Tier 4 Specialty drugs - Includes high-cost/unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations. See the *Evidence of Coverage* Chapter 5, Section 2.5 (*Using the plan's coverage for your Part D prescription drugs, When can you use a pharmacy that is not in the plan's network?*) for information.

Coverage Gap Stage: Amount you pay after you reach $4,430 in total covered prescription drug expenses and until you reach $7,050 in out-of-pocket covered prescription drug costs. Your plan's gap coverage is listed in the chart below.

Standard Cost Share: The chart below lists the amount that you pay during the coverage gap at a pharmacy that offers standard cost-sharing:

Supplemental Gap Coverage	**One-Month Supply**			**Extended Supply**	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 1 Generic drugs	You pay $10	You pay $10	You pay $10	You pay $10	You pay $9
Tier 2 Preferred brand drugs	You pay $30	You pay $30	You pay $30	You pay $30	You pay $30
Tier 3 Non-preferred brand drugs	You pay $45	You pay $45	You pay $45	You pay $45	You pay $45
Tier 4 Specialty drugs - Includes high-cost/unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations. See the *Evidence of Coverage* Chapter 5, Section 2.5 (*Using the plan's coverage for your Part D prescription drugs*, When can you use a pharmacy that is not in the plan's network?) for information.

Preferred Cost Share: The chart below lists the amount that you pay during the coverage gap at a pharmacy that offers preferred cost-sharing:

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Preferred retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Preferred retail cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 1 Generic drugs	You pay $9	You pay $10	You pay $10	You pay $9	You pay $9
Tier 2 Preferred brand drugs	You pay $30	You pay $30	You pay $30	You pay $30	You pay $30
Tier 3 Non-preferred brand drugs	You pay $45	You pay $45	You pay $45	You pay $45	You pay $45
Tier 4 Specialty drugs - Includes high-cost/unique brand and generic drugs	You pay $75	You pay $75	You pay $75	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations. See the *Evidence of Coverage* Chapter 5, Section 2.5 (*Using the plan's coverage for your Part D prescription drugs, When can you use a pharmacy that is not in the plan's network?*) for information.

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

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

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching $7,050 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	You pay 5% of the drug cost or the amounts listed in the Initial Coverage section, whichever is *less*. We will pay the rest.

Step Therapy

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

This Plan Uses the GRP B2 Plus Formulary:

Your plan uses the GRP B2 Plus formulary, which means that only drugs on Aetna's Drug List will be covered under your plan as long as the drug is medically necessary, and the plan rules are followed. Non-preferred copayment levels may apply to some drugs on the Drug List. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2022 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 weight loss
- Drugs when used to promote fertility
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Drugs when used for the treatment of erectile dysfunction
- DESI drugs

The cost share for these drugs 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. **Drugs used for the treatment of erectile dysfunction and agents when used to promote fertility can be accessed at a $50 member cost share.**

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. This document will also show limitations, such as quantity limits and prior authorization requirements. For more information, call Member Services.

NOTES

How we guard your privacy

We're committed to keeping your personal information safe

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.

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