aetna™

Aetna Medicare℠ Plan (PPO) offered by Aetna Life Insurance Company

Annual Notice of Changes for 2020

October 2019

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 2020 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. 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.

☐ 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?

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 group retiree 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 benefits administrator to see if there are other options are available.
   - Check coverage and costs of individual Medicare health plans in your area.
   - Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
   - Review the list in the back of your Medicare & You handbook.
   - Look in Section 3.2 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 3.2 to learn more about your choices.

4. **ENROLL:** To change plans, call the benefits administrator of your former employer or retiree group for information.

Additional Resources

- This document is available for free in Spanish.
- Please contact Customer Service at the telephone number on your Aetna member ID card or call our general customer service center at 1-888-267-2637 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.
- This document may be made available in other formats such as Braille, large print or other alternate formats. Please contact Customer Service for more information.
- Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.
- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aetna Medicare Plan (PPO)

- Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. 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 2020

The table below compares the 2019 costs and 2020 costs for our plan in several important areas. **Please note this is only a summary of changes**. You can also review the attached *Evidence of Coverage and Schedule of Cost Sharing* to see if other benefit or cost changes affect you.

Cost	2019 (this year)	2020 (next year)
Deductible	In-network: **$300** Combined In- and Out-of-Network Deductible: **$300**	In-network: **$300** Combined In- and Out-of-Network Deductible: **$300**
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered medical services. (See Section 1.2 for details.)	From network providers: **$3,400** From in-network and out of network providers combined: **$3,400**	From network providers: **$3,400** From in-network and out of network providers combined: **$3,400**
Doctor office visits	In-network: Primary care visits: You pay a **$5** copay for each service. Specialist visits: You pay a **$25** copay for each service.	In-network: Primary care visits: You pay a **$5** copay for each service. Specialist visits: You pay a **$25** copay for each service.

Cost	2019 (this year)	2020 (next year)
	Out-of-network: Primary care visits: You pay **20%** of the total cost. Specialist visits: You pay **20%** of the total cost.	Out-of-network: Primary care visits: You pay **20%** of the total cost. Specialist visits: You pay **20%** of the total cost.
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.	In-network: **$0 per stay** Out-of-network: **20% per stay**	In-network: **$0 per stay** Out-of-network: **20% per stay**
Part D prescription drug coverage (See Section 1.6 for details.) For a one-month (30-day) supply of a drug that is filled at a network pharmacy that provides standard cost-sharing. **The list of covered drugs associated with your plan will change for 2020. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.**	Deductible: **No Deductible** Copays during the Initial Coverage Stage: **Generic:** $10 **Preferred Brand:** $30 **Non-Preferred Brand:** $45	Deductible: **No Deductible** Copays during the Initial Coverage Stage: **Generic:** $10 **Preferred Brand:** $30 **Non-Preferred Brand:** $45

Annual Notice of Changes for 2020
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium (if applicable)

Your coverage is provided through a contract with your former employer/union/trust. The 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 an annual coupon book detailing your premium amount.

You must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.

- 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.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

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	2019 (this year)	2020 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays, coinsurance, and deductibles, if applicable) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium (if applicable) and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$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 network providers for the rest of the calendar year.

Cost	2019 (this year)	2020 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays, coinsurance, 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 prescription drugs do not count toward your maximum out-of-pocket amount.	**$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 aetnamedicare.com/findprovider. Please call Customer Service at the telephone number on your Aetna member ID card or contact our general customer service center at 1-888-267-2637. (For TTY assistance please dial 711.) You may also call Customer Service for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2020 *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 and managing 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.

There are changes to our network of pharmacies for next year. **Please review the 2020 Provider & Pharmacy Directory to see which pharmacies are in our network.** Page 1 of your *Prescription Drug Schedule of Cost Sharing* lists the name of your 2020 pharmacy network. Please refer to this network name when looking for 2020 network pharmacies. The *Prescription Drug Schedule of Cost Sharing* is enclosed in this packet.

An updated *Provider & Pharmacy Directory* is located on our website at aetnamedicare.com/findpharmacy. You may also call Customer Service for updated pharmacy information or to ask us to mail you a *Provider & 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 2020 *Schedule of Cost Sharing* included in this package.

Cost	2019 (this year)	2020 (next year)
Health and wellness education programs		
• Healthy Lifestyle Coaching Program	Covered	Healthy Lifestyle Coaching Program is not covered.
• Teladoc	Covered	Teladoc is not covered.
Hearing aid reimbursement	$500 once every 36 months	$1,000 once every 36 months

Cost	2019 (this year)	2020 (next year)
Opioid treatment program services	Not Covered	In-network: You pay $0 Out-of-network: You pay 20%
Transportation (non-emergency transportation that is not covered by Medicare)	Transportation is not included	You pay a $0 copay per trip 24 one-way trips to and from plan-approved locations each year Trips must be within 60 miles of provider location.

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 in this envelope.

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. **We encourage current members** to ask for an exception before next year.
    - 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 Customer Service.
- **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 will 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*.) After you get this temporary supply, you should talk with your doctor to decide what to do when your temporary supply runs out. Here are your options:

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. Your doctor can help 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* included with this *Annual Notice of Changes.* Look for Chapter 9, Section 6 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You can ask for an exception for Part D drugs that are not on the formulary. You can also ask for an exception for Part D drugs that are on our formulary but with a restriction, such as prior authorization, step therapy, or quantity limit.

If you are currently taking a Part D drug that will no longer be on the formulary as of January 1, 2020, or a Part D drug that will have new restrictions on it beginning on January 1st, you can ask for an exception before that date to make sure we will continue covering that drug. Here is what will happen if you do not request an exception for those drugs before January 1, 2020:

- If the Part D drug you are taking will no longer be on the formulary or will have a restriction beginning January 1, 2020, we will cover up to a 30-day temporary supply (unless your prescription is written for fewer days) of the Part D drug for the first 90 days of the new plan year starting on January 1st.
- If you live in a long-term care facility and the Part D drug you are taking will no longer be on the formulary or will have a restriction beginning January 1, 2020, we will allow you to refill your prescription until we have provided you with at least a 31-day supply, consistent with the dispensing increment (unless your prescription is written for fewer days). We will cover more than one refill of this drug for the first 90 days of the new plan year 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 advantage of filing 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* that was included in the mailing with this Annual Notice of Changes. Look for Chapter 9 of the *Evidence of Coverage* (What to do if you have a problem or complaint).

As we did in 2019, we may immediately remove a brand name drug on our Drug List, or we may move the brand name drug to a higher cost share tier, if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This

means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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. If you receive "Extra Help" and haven't received this insert by September 30, 2019, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

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	2019 (this year)	2020 (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 for certain tier drugs may be changing from copayment to coinsurance *or* coinsurance to copayment. Please see the following chart for the changes from 2019 to 2020.

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	2019 (this year)	2020 (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 cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in the 2020 *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: $10 Preferred Brand: $30 Non-Preferred Brand: $45 Once your total drug costs have reached $3,820, 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: $10 Preferred Brand: $30 Non-Preferred Brand: $45 Once your total drug costs have reached $4,020, 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 2020 *Prescription Drug Schedule of Cost Sharing* included in this packet.

SECTION 2 Administrative Changes

Process	2019 (this year)	2020 (next year)
Coverage Decisions for Part D Prescription Drugs -fax number	1-800-408-2386	1-724-741-4954

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Aetna Medicare Plan (PPO)

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

Section 3.2 – 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.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 2.1 regarding a potential Part D enrollment penalty.

It is important that you carefully consider your decision before dropping your group retiree 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 the benefits administrator of your former employer or retiree group for information.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Aetna offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
    - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan,** you must either:

- Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 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 4 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's 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 dropping your group retiree 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 the benefits administrator of your former employer or retiree group for information.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

SHIPs are independent (not connected with any insurance company or health plan). They are state programs that get 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 your SHIP at the phone number in Addendum A at the back of the *Evidence of Coverage.*

SECTION 6 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 a.m. and 7 p.m., 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 state pharmaceutical assistance programs (SPAPs) that help people pay for prescription drugs based on their financial need, age, or medical condition. Each state has different rules. 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 state ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP (the name and phone numbers for this organization are in Addendum A at the back of the *Evidence of Coverage*).

SECTION 7 Questions?

Section 7.1 – Getting Help from Aetna Medicare Plan (PPO)

Questions? We're here to help. Please call Customer Service at the telephone number on your Aetna member ID card or call our general customer service center at 1-888-267-2637. (TTY only, call 711.) We are available for phone calls 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are free.

Read your 2020 *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 2020. For details about your plan, look in the *2020 Evidence of Coverage* and the *Schedule of Cost Sharing*. 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 included in this envelope. The *Schedule of Cost Sharing* lists the out of pocket cost share for your plan, a copy is included in this envelope.

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 & Pharmacy Directory*) and our list of covered drugs (*Formulary/Drug List*).

Section 7.2 – 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 (https://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 https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read *Medicare & You 2020* 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 (https://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.

Aetna Life Insurance Company

Former Employer/Union/Trust Name: **STATE OF MAINE**
Group Agreement Effective Date: **01/01/2020**
Group Number: **457441**

This Schedule of Cost Sharing is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the attachment for information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.)

	FOR SERVICES RECEIVED IN-NETWORK	FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED
Annual Deductible		
This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered Medicare Part A and B services.	$300 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	$300 Combined In- and Out-of-Network Deductible (Plan Level/includes network Deductible) Out-of-network: Deductible waived for Preventive Services, Emergency Room Visits, Emergency Ambulance, Urgent Care, and applicable Riders and Temporomandibular Joint Dysfunction
Annual Maximum Out-of-Pocket Limit		
The maximum out-of-pocket limit is the most you will pay for covered benefits including any deductible (if applicable).	Maximum out-of-pocket amount for in-network services: $3,400	Combined maximum out-of-pocket amount for in- and out-of- network services: $3,400

Important information regarding the services listed below in the Medical Benefits Chart:

If you receive services from:	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.

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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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.	You pay 20% of the cost for members eligible for this preventive screening.
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. Aetna 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.	You pay a $25 copay for each Medicare-covered one-way trip.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	Annual physical exam 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 benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" Preventive Visit.	You pay a $0 copay for the exam.	You pay 20% of the cost of the 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. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	You pay 20% of the cost 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	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.	You pay 20% of the cost for Medicare-covered bone mass measurement.
	Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.	You pay 20% of the cost for covered screening mammograms.
	Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay a $20 copay for each Medicare-covered cardiac rehabilitation visit.	You pay 20% of the cost for each Medicare-covered cardiac rehabilitation visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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.	You pay 20% of the cost for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	You pay 20% of the cost 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 Papt 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.	You pay 20% of the cost for Medicare-covered preventive Pap and pelvic exams.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	Chiropractic services • 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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay per Medicare-covered visit.	You pay 20% of the cost of each Medicare-covered visit.
	Chiropractic services-enhanced: In addition to the chiropractic service described above, we cover other routine services you receive from a licensed chiropractor	You pay a $20 copay for each visit.	You pay a $20 copay for each visit.
	Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.	You pay 20% of the cost for a Medicare-covered colorectal cancer screening exam.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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 **Note:** A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the Outpatient surgery cost sharing. **(See "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" for more information)**		
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.	$0 per pair.	20% per pair.
Dental services Medicare covered services include: • Non-routine dental care (covered services are limited to surgery of the jaw or related	You pay a $25 copay for each Medicare-covered (non-routine) dental care service.	You pay 20% of the cost for each Medicare-covered (non-routine) dental care service.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**		
	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.	You pay 20% of the cost for an annual depression screening visit.
	Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. 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.	You pay 20% of the cost for the Medicare covered diabetes screening tests.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions	You pay a $0 copay per Medicare-covered diabetic service or supply. You pay $0 for each pair of Medicare-covered diabetic shoes/inserts. $0 copay for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit.	You pay 20% of the cost per Medicare-covered diabetic service or supply. You pay 20% of the cost for each pair of Medicare-covered diabetic shoes/inserts. You pay 20% of the cost for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit.
• Urine Test Strips	You pay a $0 copay for urine test strips.	You pay 20% of the cost for urine test strips.
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*.)	You pay a $0 copay for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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 aetnamedicare.com/findprovider. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.** • Coverage for foot orthotics	You pay a $0 copay for foot orthotics.	You pay 20% of the cost for foot orthotics.
We cover wigs for hair loss due to chemotherapy.	$0	
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	You pay a $75 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.	You pay a $75 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	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.	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to an in- network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.
	**Health and wellness education programs**		

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services **In-Network**	What you must pay (after any deductible listed on page 1) when you get these services **Out-of-network**
• **Fitness Benefit** The Aetna fitness benefit gives you a free monthly membership, including group exercise classes, at a participating fitness club and facility. Plan members who don't live close to a participating facility or want to exercise at home can order a home fitness kit. We work with another company to manage this benefit.	SilverSneakers® Fitness Program is included in your plan. We're here to help and give you more information. • Call us at **1-888-423-4632**. (For TTY/TDD assistance please dial 711.) • Visit http://www.silversneakers.com to find a participating location near you.	
• **Informed Health® Line** Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options.	Included in your plan. Call us at **1-800-556-1555.** (For TTY/TDD assistance please dial 711.)	
• **Resources for Living℠** – Resources for Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life related issues.	Included in your plan. Call Resources for Living at **1-866-370-4842**.	
• **Written health education materials**	Included in your plan.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider	You pay a $25 copay for each Medicare-covered service.	You pay 20% of the total cost for Medicare-covered services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
• Our plan covers one routine hearing exam every 12 months	You pay a $0 copay for one routine hearing exam every 12 months.	You pay 20% of the cost for one routine hearing exam every 12 months.
• Hearing aid reimbursement Amounts you pay for hearing aids do not count toward your annual maximum out-of-pocket amount.	Our plan will reimburse you up to $1,000 once every 36 months towards the cost of hearing aids.	
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.	You pay 20% of the cost for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total	You pay a $0 copay for each Medicare-covered home health visit. You pay a $0 copay for each Medicare-covered durable medical equipment item.	You pay 20% of the cost for each Medicare-covered home health visit. You pay 20% of the cost for each Medicare-covered durable medical equipment item.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**		
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: • 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	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.	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.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network 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*).		

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit. Palliative care consultation is also available.	Hospice consultations are included as part of **Inpatient Hospital Care**. Physician service cost sharing may apply for outpatient consultations.	Hospice consultations are included as part of **Inpatient Hospital Care**. Physician service cost sharing may apply for outpatient consultations.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. You pay a $0 copay for other Medicare-covered Part B vaccines. You may have to pay an office visit cost-share if you get other services at the same time that you get vaccinated.	$0 copay for pneumonia, influenza, and Hepatitis B vaccines. You pay 20% of the cost 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.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of days covered by our plan. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a	For Medicare-covered hospital stays, you pay: $0 per stay Cost-sharing is charged for each inpatient stay.	For Medicare-covered hospital stays: 20% per stay Cost-sharing is charged for each inpatient stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion • Blood - including storage and administration. All components of blood 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		

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
– Ask!" This fact sheet is available on the Web at https://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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**		
Inpatient mental health care • Covered services include mental health care services that require a hospital stay • There is no limit to the number of days covered by our plan **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	For Medicare-covered hospital stays, you pay: $0 per stay Cost-sharing is charged for each inpatient stay.	For Medicare-covered hospital stays, you pay: 20% per stay Cost-sharing is charged for each 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	You pay a $5 copay for each primary care doctor visit for Medicare-covered benefits.	You pay 20% of the cost for each primary care doctor visit for Medicare-covered benefits.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each specialist visit for Medicare-covered benefits. You pay a $0 copay for each Medicare-covered diagnostic procedure or test. You pay a $0 copay for Medicare-covered lab services. 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 Medicare-covered therapeutic radiology services.	You pay 20% of the cost for each specialist visit for Medicare-covered benefits. You pay 20% of the total cost of the Medicare-covered diagnostic procedures or tests. You pay 20% of the cost for Medicare-covered lab services. You pay 20% of the cost for each Medicare-covered X-ray. You pay 20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service. You pay 20% of the cost for Medicare-covered therapeutic radiology services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	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 DME item. You pay a $20 copay for each Medicare-covered physical, speech or occupational therapy visit.	You pay 20% of the cost of service medical supply items received from a PCP. You pay 20% of the cost of service medical supply items received from other providers. You pay 20% of the cost for each Medicare-covered prosthetic and orthotic item. You pay 20% of the cost for each Medicare-covered DME item. You pay 20% of the cost for each Medicare-covered physical, speech or occupational therapy visit.
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	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered	You pay 20% of the cost 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 3 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.	medical nutrition therapy 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.	You pay 20% of the cost for Medicare-covered 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	You pay a $0 copay per prescription or refill.	You pay 20% of the cost per prescription or refill.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
• 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 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 Part B drugs may be subject to step therapy requirements. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: aetna.com/partb-step. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay		

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	for your Part D prescription drugs through our plan is explained in Chapter 6. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**		
	Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	You pay 20% of the cost for preventive obesity screening and therapy.
	Opioid Treatment Program Services Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	You pay $0	You pay 20%
	Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:	Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/supplies	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services **In-Network**	What you must pay (after any deductible listed on page 1) when you get these services **Out-of-network**
• X-rays	- the setting where the tests/services/supplies are performed.	
• 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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	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 Medicare-covered lab services. You pay a $0 copay for Medicare-covered diagnostic procedures or tests. You pay a $0 copay for Medicare-covered therapeutic radiology services. You pay a $5 copay for Medicare-covered medical supply items received from a PCP.	You pay 20% of the cost for each Medicare-covered X-ray. You pay 20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service. You pay 20% of the cost for Medicare-covered lab services. You pay 20% of the cost for Medicare-covered diagnostic procedures or tests. You pay 20% of the cost for Medicare-covered therapeutic radiology services. You pay 20% of the cost of service medical supply items received from a PCP.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	You pay a $25 copay for Medicare-covered medical supply items received from other providers.	You pay 20% of the cost of service medical supply items 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 https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by	Your cost share for Observation Care is based upon the services you receive.	Your cost share for Observation Care is based upon the services you receive.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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.		
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an	You pay a $50 copay per facility visit.	You pay 20% of the cost of the facility visit.
	Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed.	
	You pay a $5 copay for each primary care doctor visit for Medicare-covered benefits. You pay a $25 copay for each specialist visit for Medicare-covered benefits. You pay a $0 copay for Medicare-covered lab services.	You pay 20% of the cost for each primary care doctor visit for Medicare-covered benefits. You pay 20% of the cost for each specialist visit for Medicare-covered benefits. You pay 20% of the cost for Medicare-covered lab services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
"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 https://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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered diagnostic procedure and test. For Medicare-covered mental health services, you pay $0 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 Medicare-covered therapeutic radiology services. You pay a $0 copay for each Medicare-covered partial hospitalization visit.	You pay 20% of the total cost for Medicare-covered diagnostic procedures and tests. For Medicare-covered mental health services, you pay 20% You pay 20% of the cost for each Medicare-covered X-ray. You pay 20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service. You pay 20% of the cost for Medicare-covered therapeutic radiology services. You pay 20% of the cost for each Medicare-covered partial hospitalization visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	You pay a $5 copay for Medicare-covered medical supply items received from a PCP.	You pay 20% of the cost of service medical supply items received from a PCP.
	You pay a $25 copay for Medicare-covered medical supply items received from other providers.	You pay 20% of the cost of service 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 20% of the cost per prescription or refill for certain drugs and biologicals that you can't give yourself.
	You pay a $75 copay for each Medicare-covered emergency room visit.	You pay a $75 copay for each Medicare-covered emergency room visit.
	If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.	If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.
	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to an

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
		inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.	in- network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.)
	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. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay $0	You pay 20%

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered outpatient rehabilitation service visit.	You pay 20% of the cost for each Medicare-covered outpatient rehabilitation service visit.
	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	You pay $0	You pay 20%

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
Medicare eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief interventions or advice focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**		
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. You pay a $50 copay for each Medicare-covered outpatient hospital facility visit. You pay a $50 copay for each Medicare-covered ambulatory surgical center visit.	You pay 20% of the cost for each Medicare-covered outpatient hospital facility visit. You pay 20% of the cost for each Medicare-covered ambulatory surgical center visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $0 copay for each Medicare-covered visit.	You pay 20% of the cost for each Medicare-covered visit.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, walk-in clinic, (non-urgent) 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 consultation, diagnosis, and treatment by a physician or practitioner for patients in	Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/ supplies - the setting where the tests/services/ supplies are performed.	
	You pay a $5 copay for each primary care doctor visit for Medicare-covered benefits.	You pay 20% of the cost for each primary care doctor visit for Medicare-covered benefits.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
certain rural areas or other locations approved by Medicare • 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 requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each specialist visit for Medicare-covered benefits. You pay a $25 copay for each Medicare-covered hearing exam. 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 20% of the cost for each specialist visit for Medicare-covered benefits. You pay 20% of the total cost of the Medicare-covered hearing exam. You pay 20% of the cost for each Medicare-covered (non-routine) dental care service. You pay a $0 copay for Medicare-covered allergy testing.
Podiatry services Medicare-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 $5 copay for Medicare-covered podiatry services received from your PCP. You pay a $25 copay for each Medicare-covered podiatry services received from other providers.	You pay 20% of the cost for Medicare-covered podiatry services received from your PCP. You pay 20% of the cost for each Medicare-covered podiatry services received from other providers.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	Podiatry services - enhanced benefit (Non-Medicare covered) routine podiatry - The reduction of nails, including mycotic nails and the removal of corns and calluses.	$5 copay for routine podiatry services received from your PCP. $20 copay for routine podiatry services received from other providers.	20% of the cost for routine podiatry services received from your PCP. 20% of the cost for routine podiatry services received from other providers.
	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 20% of the cost for an annual PSA test.
	Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and 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. Aetna recommends**	You pay a $0 copay for each Medicare-covered item.	You pay 20% of the cost for each Medicare-covered item.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	pre-authorization of the service when provided by an out-of-network provider.		
	Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay a $20 copay for each Medicare-covered pulmonary rehabilitation visit.	You pay 20% of the cost for each Medicare-covered pulmonary rehabilitation visit.
	Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	You pay 20% of the cost for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
	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	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	You pay 20% of the cost 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	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.		
	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	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	You pay 20% of the cost 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.		
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the Evidence of Coverage) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For	You pay a $0 copay for self-dialysis training and kidney disease education services. You pay a $0 copay for in- and out-of area outpatient dialysis. Inpatient dialysis – refer to **"Inpatient Hospital Care"** You pay a $0 copay for home dialysis equipment and supplies. You pay a $0 copay for Medicare-covered home support services.	You pay 20% of the cost for self-dialysis training and kidney disease education. You pay a $0 copay for in- and out-of area outpatient dialysis. Inpatient dialysis – refer to **"Inpatient Hospital Care"** You pay 20% of the cost for home dialysis equipment and supplies. You pay 20% of the cost 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**		
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") We cover 100 days per benefit period. A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)	For Medicare-covered SNF stays, you pay: $0 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.	For Medicare-covered SNF stays, you pay: 20% A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
• 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 Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Aetna 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	You pay 20% of the cost for the Medicare-covered smoking and tobacco use cessation preventive benefits.
	Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office	You pay a $20 copay for each service.	You pay 20% of the total cost of the service.

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

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
• 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		
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. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each visit.	$0 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 In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
	Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Coverage is available worldwide.	You pay a $20 copay for each Medicare-covered urgent care visit received at an urgent care facility.	You pay a $20 copay for each Medicare-covered urgent care visit received at an urgent care facility.
	**Vision care** Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	You pay a $25 copay for exams to diagnose and treat diseases and conditions of the eye.	You pay 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.
	• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older.	You pay a $0 copay for one glaucoma screening every 12 months.	You pay 20% of the cost for one glaucoma screening every 12 months.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
• For people with diabetes, screening for diabetic retinopathy is covered once per year	You pay a $0 copay for one diabetic retinopathy screening every 12 months.	You pay 20% of the cost for one diabetic retinopathy screening every 12 months.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	You pay a $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.	You pay a $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.
Our plan covers one routine eye exam every 12 months.	You pay a $0 copay for one routine eye exam every 12 months.	You pay 20% of the cost for one routine eye exam every 12 months.
"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.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.	You pay 20% of the cost for the "Welcome to Medicare" preventive visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services In-Network	What you must pay (after any deductible listed on page 1) when you get these services Out-of-network
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.		

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

Aetna Life Insurance Company

Former Employer/Union/Trust Name: STATE OF MAINE
Group Agreement Effective Date: 01/01/2020
Group Number: 457441

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

Annual Deductible Amount	$0
Formulary Type:	GRP B2 Plus
Number of Cost Share Tiers:	3 Tier
Initial Coverage Limit:	$4,020
True Out-of-Pocket Amount:	$6,350

Retail Pharmacy Network: S2

The name of your pharmacy network is listed above. To find a network pharmacy, or find up-to-date information about our network pharmacies, please call Customer Service at the number on the back of your member ID card or consult the online *Pharmacy Directory* at aetnamedicare.com/findpharmacy.

Enhanced Drug Benefit

We offer additional coverage of 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 table below. 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. Limitations, such as quantity limits and prior authorization requirements, can be found in the formulary included in this mailing. In addition, if you are receiving “Extra Help” from Medicare to pay for your prescriptions, the “Extra Help” will not pay for these drugs. Please refer to your formulary or call Customer Service for more information.

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

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 $4,020 in total covered prescription drug expenses.

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	$10	$10	$10	$10	$10
Tier 2 Preferred brand drugs	$30	$30	$30	$30	$30
Tier 3 Non-preferred brand drugs	$45	$45	$45	$45	$45

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

Coverage Gap Stage: Amount you pay after you reach $4,020 in total covered prescription drug expenses and until you reach $6,350 in out-of-pocket covered prescription drug costs.

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

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	$10	$10	$10	$10	$10
Tier 2 Preferred brand drugs	$30	$30	$30	$30	$30
Tier 3 Non-preferred brand drugs	$45	$45	$45	$45	$45

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

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

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

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching $6,350 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*. Our plan pays the rest of the cost.

Step Therapy

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

This Plan Uses the GRP B2 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 2020 Group Formulary (List of Covered Drugs)* for more information.