# Aetna Medicare

Former Employer/Union/Trust Name: **The Dow Chemical Company**
Group Agreement Effective Date: **01/01/2023**
Master Plan ID: **0000530, 0005687**

This *Schedule of Cost Sharing* is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the document with information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (What is covered and what you pay)*.) If you have questions, please call our Member Services at the telephone number printed on your member ID card or call our Member Services at 1-855-344-2209. (TTY users should call 711.) Hours are 8 AM to 9 PM ET, Monday through Friday.

| **Annual Deductible** | **FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED** |
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| This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered Medicare Part A and B services. | **No Deductible** |
| **Annual Maximum Out-of-Pocket Limit** | **FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED** |
| The maximum out-of-pocket limit is the most you will pay for covered Medicare Part A and B services, including any deductible (if applicable). | **$2,500** |

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

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

# Medical Benefits Chart

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

| Services that are covered for you | What you must pay when you get these services |
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| **Abdominal aortic aneurysm screening**<br>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. | There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. |
| **Acupuncture for chronic low back pain**<br>Covered services include:<br>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:<br><br>For the purpose of this benefit, chronic low back pain is defined as:<br><br>• Lasting 12 weeks or longer;<br>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);<br>• not associated with surgery; and<br>• not associated with pregnancy.<br><br>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.<br><br>Treatment must be discontinued if the patient is not improving or is regressing.<br><br>Provider Requirements:<br>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.<br><br>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:<br><br>• a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by | $25 copay for each Medicare-covered acupuncture visit. |

| Services that are covered for you | What you must pay when you get these services |
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| the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.<br><br>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. | |
| **Ambulance services**<br><br>• 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.<br>• 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.<br><br>**Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.** | $150 copay for each Medicare-covered one-way trip via ground or air ambulance. |
| **Annual routine physical**<br>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.<br><br>Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" preventive visit. You may schedule your annual routine physical once each calendar year. | $0 copay for an annual routine physical exam. |

| Services that are covered for you | What you must pay when you get these services |
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| Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. Please see "**Outpatient diagnostic tests and therapeutic services and supplies**" for more information. | |
| **Annual wellness visit**<br>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year.<br><br>**Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months. | There is no coinsurance, copayment, or deductible for the annual wellness visit. |
| **Bone mass measurement**<br>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. | There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. |
| **Breast cancer screening (mammograms)**<br>Covered services include:<br><br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram each calendar year for women aged 40 and older<br>• Clinical breast exams once every 24 months | There is no coinsurance, copayment, or deductible for covered screening mammograms.<br><br>$0 copay for each diagnostic mammogram. |
| **Cardiac rehabilitation services**<br>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. | $25 copay for each Medicare-covered cardiac rehabilitation visit.<br><br>$25 copay for each Medicare-covered intensive cardiac rehabilitation visit. |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** | There is no coinsurance, copayment, or deductible for the intensive behavioral |

| Services that are covered for you | What you must pay when you get these services |
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| 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. | therapy cardiovascular disease preventive benefit. |
| **Cardiovascular disease testing**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>• For all women: Pap tests and pelvic exams are covered once every 24 months<br>• If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months | There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. |
| **Chiropractic services**<br>Covered services include:<br>• We cover only manual manipulation of the spine to correct subluxation<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $20 copay for each Medicare-covered chiropractic visit. |
| **Colorectal cancer screening**<br>For people 50 and older, the following are covered:<br>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months<br><br>Two of each of the following per calendar year:<br>• Guaiac-based fecal occult blood test (gFOBT)<br>• Fecal immunochemical test (FIT)<br><br>DNA based colorectal screening every 3 years | There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.<br><br>$0 copay for each Medicare-covered preventive barium enema.<br><br>If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology will be covered at $0 copay as these procedures were performed during a preventive service.<br><br>Diagnostic colonoscopy is covered at $0 copay when you schedule a diagnostic |

| Services that are covered for you | What you must pay when you get these services |
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| For people at high risk of colorectal cancer, we cover:<br>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months<br><br>For people not at high risk of colorectal cancer, we cover:<br>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy | colonoscopy after having a Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT).<br><br>If you have had polyps removed during a previous colonoscopy or have a condition that is monitored via colonoscopy (such as a prior history of colon cancer), ongoing colonoscopies are considered diagnostic, and are subject to the outpatient surgery cost-sharing.<br><br>(See **"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"** for more information.) |
| **Dental services**<br>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:<br>• 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)<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $25 copay for each Medicare-covered dental care service. |
| **Depression screening**<br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. | There is no coinsurance, copayment, or deductible for an annual depression screening visit. |
| **Diabetes screening**<br>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. | There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. |

| Services that are covered for you | What you must pay when you get these services |
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| Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. | |
| **Diabetes self-management training, diabetic services and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include:<br>• 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.<br>• 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.<br>• Diabetes self-management training is covered under certain conditions.<br><br>You should order your LifeScan starter kit, including the model of meter you prefer, by contacting LifeScan directly at 1-877-764-5390. Use order code: 123AET200. LifeScan will send you a starter kit in the mail that includes the meter you selected, a small supply of lancets and test strips, as well as usage and educational materials. You should also reach out to your physician to obtain a prescription for LifeScan test strips that you can fill at your network pharmacy.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $0 copay for each Medicare-covered supply to monitor blood glucose from OneTouch/LifeScan, or from a non-preferred provider when a prior authorization is received.<br><br>$0 copay for each pair of Medicare-covered diabetic shoes and inserts.<br><br>$0 copay for Medicare-covered diabetes self-management training.<br><br>We cover diabetic supplies made by OneTouch/LifeScan. We exclusively cover OneTouch/LifeScan glucose monitors and test strips. We also cover OneTouch/LifeScan lancets, solutions, and lancing devices. We do not cover other brands of monitors and test strips unless you or your provider requests a medical exception and it is approved. Non-LifeScan monitors and test strips without a medical exception, or a medical exception that is not approved, will not be covered. |
| **Durable medical equipment (DME) and related supplies**<br>(For a definition of “durable medical equipment,” see Chapter 12 of the *Evidence of Coverage*.)<br><br>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, | 20% of the total cost for each Medicare-covered durable medical equipment item.<br><br>$0 copay for continuous glucose meters. |

| Services that are covered for you | What you must pay when you get these services |
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| diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.<br><br>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: Dow.AetnaMedicare.com.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | |
| **Emergency care**<br>Emergency care refers to services that are:<br><br>• Furnished by a provider qualified to furnish emergency services, and<br>• Needed to evaluate or stabilize an emergency medical condition.<br><br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.<br><br>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.<br><br>This coverage is available worldwide (i.e., outside of the United States). | $65 copay for each emergency room visit. Cost-sharing is waived if you are immediately admitted to the hospital. |
| **Fitness program (physical fitness)**<br>You are covered for a basic membership to any SilverSneakers® participating fitness facility.<br><br>At-home fitness kits and online classes are also available if you do not reside near a participating club or prefer to exercise at home. You may order one fitness kit per year through SilverSneakers. | $0 copay for health club membership/fitness classes. |

| Services that are covered for you | What you must pay when you get these services |
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| You will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self help, and staying connected. These classes can be accessed online by visiting SilverSneakers.com.<br><br>To get started, you will need your SilverSneakers ID number. Please visit SilverSneakers.com or call SilverSneakers at 1-888-423-4632 (TTY/TDD: 711) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers. | |
| **Health and wellness education programs**<br><br>• **24-Hour Nurse Line:** Talk to a registered nurse 24 hours a day, 7 days a week. Please call **1-855-493-7019** (For TTY/TDD assistance, please dial 711.)<br><br>• **Health education:** Members are eligible to receive the health education supplemental benefit to support a healthier lifestyle. This benefit gives members the opportunity to interact as a group, one-on-one, or virtually, with a certified health educator or other qualified health professional. Members may receive educational supplies such as books and pamphlets to augment their interactive sessions. In addition, members will be encouraged to adopt healthy habits and build skills to enhance self-care capabilities. | There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line benefit.<br><br>Health education is included in your plan. |
| **Healthy Rewards**<br>The Aetna Healthy Rewards program is a highly personalized incentive and rewards program. Plan members can earn rewards in the form of merchandise gift cards by completing specific health and wellness activities within the plan year. Coinsurance, copayment, or deductible may apply to the medical service completed in order to earn the reward. There is no out-of-pocket cost to the member to redeem the reward once the required activity is complete. | Included in your plan. |

| Services that are covered for you | What you must pay when you get these services |
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| **Hearing services**<br>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.<br><br>In addition to Medicare-covered benefits, we also offer:<br><br>• Routine hearing exams: one every twelve months | $25 copay for each Medicare-covered hearing exam.<br><br>$0 copay for each non-Medicare covered hearing exam. |
| **Hearing services - Hearing aids**<br>This is a reimbursement benefit towards the cost of hearing aids. You may see any licensed hearing provider in the U.S. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment. If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing information, which will delay the processing time.<br><br>**Notes:**<br><br>• If you use a non-licensed provider you will not receive reimbursement.<br>• You are responsible for any charges above the reimbursement amount.<br><br>***** *Amounts you pay for hearing aids do not apply to your Out-of-Pocket Maximum.* | Our plan will reimburse you up to $500 once every 36 months towards the cost of hearing aids. |
| **HIV screening**<br>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:<br><br>• One screening exam every 12 months<br><br>For women who are pregnant, we cover:<br><br>• Up to three screening exams during a pregnancy | There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. |
| **Home health agency care**<br>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 | $0 copay for each Medicare-covered home health visit.<br><br>20% of the total cost for each |

| Services that are covered for you | What you must pay when you get these services |
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| agency. You must be homebound, which means leaving home is a major effort.<br><br>Covered services include, but are not limited to:<br><br>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services<br>• Medical equipment and supplies<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | Medicare-covered durable medical equipment item. |
| **Home infusion therapy**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).<br><br>Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan.<br><br>Covered services include, but are not limited to:<br><br>• Professional services, including nursing services, furnished in accordance with the plan of care<br>• Patient training and education not otherwise covered under the durable medical equipment benefit<br>• Remote monitoring<br>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | You will pay the cost-sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services.<br><br>(See ***"Physician/Practitioner Services, Including Doctor's Office Visits"*** or ***"Home Health Agency Care"*** for any applicable cost-sharing.)<br><br>Please note that home infusion drugs, pumps, and devices provided during a home infusion therapy visit are covered separately under your ***"Durable medical equipment (DME) and related supplies"*** benefit. |
| **Hospice care**<br>You are eligible for the hospice benefit when your doctor | When you enroll in a Medicare-certified hospice program, your hospice services and |

| Services that are covered for you | What you must pay when you get these services |
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| and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<br><br>Covered services include:<br><br>• Drugs for symptom control and pain relief<br>• Short-term respite care<br>• Home care<br><br>When you are admitted to a hospice you have the right to remain in your plan; if you choose to remain in your plan you must continue to pay plan premiums.<br><br>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.<br><br>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, you pay your plan cost-sharing amount for these services and you must follow plan rules (such as if there is a requirement to obtain prior authorization).<br><br>For services that are covered by Aetna Medicare Plan (PPO) but are not covered by Medicare Part A or B: Aetna Medicare Plan (PPO) 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.<br><br>For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal | your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.<br><br>Hospice consultations are included as part of inpatient hospital care. Physician service cost-sharing may apply for outpatient consultations. |

| Services that are covered for you | What you must pay when you get these services |
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| hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice)* of your *Evidence of Coverage*.<br><br>**Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.<br><br>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | |
| **Immunizations**<br>Covered Medicare Part B services include:<br>• Pneumonia vaccine<br>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary<br>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B<br>• COVID-19 vaccine<br>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules<br><br>We also cover some vaccines under our Part D prescription drug benefit. | There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.<br><br>$0 copay for other Medicare-covered Part B vaccines.<br><br>You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated. |
| **Inpatient hospital care**<br>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.<br><br>Days covered: There is no limit to the number of days covered by our plan. Cost-sharing is not charged on the day of discharge.<br><br>Covered services include but are not limited to:<br>• Semi-private room (or a private room if medically | For each inpatient hospital stay, you pay: $200 per day, days 1-7; $0 unlimited additional days.<br><br>Cost-sharing is charged for each medically necessary covered inpatient stay. |

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

| Services that are covered for you | What you must pay when you get these services |
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| are an inpatient or an outpatient, you should ask the hospital staff.<br><br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-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.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | |
| **Inpatient services in a psychiatric hospital**<br>Covered services include mental health care services that require a hospital stay.<br><br>Days covered: There is no limit to the number of days covered by our plan. Cost-sharing is not charged on the day of discharge.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | For each inpatient stay, you pay: $200 per day, days 1-7; $0 unlimited additional days.<br><br>Cost-sharing is charged for each medically necessary covered inpatient stay. |
| **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay**<br>If you have exhausted your skilled nursing facility benefits or if the skilled nursing facility or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF).<br><br>Covered services include, but are not limited to:<br><br>• Physician services<br>• Diagnostic tests (like lab tests)<br>• X-ray, radium, and isotope therapy including technician materials and services | $15 copay for Medicare-covered primary care physician (PCP) services.<br><br>$25 copay for Medicare-covered specialist services.<br><br>$25 copay for each Medicare-covered diagnostic procedure and test.<br><br>$25 copay for each Medicare-covered lab service.<br><br>$0 copay for certain Medicare-covered lab services including Hemoglobin A1c, Urine Protein, Prothrombin (Protime), Urine |

| Services that are covered for you | What you must pay when you get these services |
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| • Surgical dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• 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<br>• 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<br>• Physical therapy, speech therapy, and occupational therapy<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | Albumin, Fecal immunochemical test (FIT), Kidney Health Evaluation for members with Diabetes (KED), and COVID-19 testing.<br><br>$25 copay for each Medicare-covered diagnostic radiology and complex imaging service.<br><br>$25 copay for each Medicare-covered x-ray.<br><br>$25 copay for each Medicare-covered therapeutic radiology service.<br><br>Your cost share for medical supplies is based upon the provider of services.<br><br>$0 copay for continuous glucose meter supplies.<br><br>20% of the total cost for each Medicare-covered prosthetic device.<br><br>$25 copay for each Medicare-covered physical or speech therapy visit.<br><br>$25 copay for each Medicare-covered occupational therapy visit. |
| **Medical nutrition therapy**<br>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.<br><br>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. | There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. |
| **Medicare Diabetes Prevention Program (MDPP)**<br>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. | There is no coinsurance, copayment, or deductible for the MDPP benefit. |

| Services that are covered for you | What you must pay when you get these services |
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| 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. | |
| **Medicare Part B prescription drugs**<br>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.<br><br>Covered drugs include:<br><br>• 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<br>• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan<br>• Clotting factors you give yourself by injection if you have hemophilia<br>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant<br>• 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<br>• Antigens<br>• Certain oral anti-cancer drugs and anti-nausea drugs<br>• 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)<br>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>• Allergy shots<br><br>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: Aetna.com/partb-step.<br><br>We also cover some vaccines under our Part B and Part D prescription drug benefit.<br><br>Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must | $0 copay per prescription or refill.<br><br>$0 copay for each chemotherapy or infusion therapy Part B drug.<br><br>$25 copay for the administration of the chemotherapy drug as well as for infusion therapy.<br><br>$0 copay for each allergy shot. You may have to pay an office visit cost share if you get other services at the same time that you get the allergy shot.<br><br>Part B drugs may be subject to Step Therapy requirements. |

| Services that are covered for you | What you must pay when you get these services |
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| follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 of the *Evidence of Coverage*.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | |
| **Obesity screening and therapy to promote sustained weight loss**<br>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. | There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. |
| **Opioid treatment program services**<br>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:<br><br>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications<br>• Dispensing and administration of MAT medications (if applicable)<br>• Substance use counseling<br>• Individual and group therapy<br>• Toxicology testing<br>• Intake activities<br>• Periodic assessments<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $25 copay for each Medicare-covered opioid use disorder treatment service. |
| **Outpatient diagnostic tests and therapeutic services and supplies**<br>Covered services include, but are not limited to:<br><br>• X-rays<br>• Radiation (radium and isotope) therapy including | Your cost share is based on:<br><br>• the tests, services, and supplies you receive<br>• the provider of the tests, services, and supplies |

| Services that are covered for you | What you must pay when you get these services |
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| technician materials and supplies<br>• Surgical supplies, such as dressings<br>• Diagnostic radiology and complex imaging such as: MRI, MRA, PET scan<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• Laboratory tests<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used.<br>• Other outpatient diagnostic tests<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | • the setting where the tests, services, and supplies are performed<br><br>$25 copay for each Medicare-covered x-ray.<br><br>$25 copay for each Medicare-covered diagnostic radiology and complex imaging service.<br><br>$25 copay for each Medicare-covered lab service.<br><br>$0 copay for certain Medicare-covered lab services including Hemoglobin A1c, Urine Protein, Prothrombin (Protime), Urine Albumin, Fecal immunochemical test (FIT), Kidney Health Evaluation for members with Diabetes (KED), and COVID-19 testing.<br><br>$0 copay for Medicare-covered blood services.<br><br>$25 copay for each Medicare-covered diagnostic procedure and test.<br><br>$25 copay for each Medicare-covered CT scan.<br><br>$25 copay for each Medicare-covered diagnostic radiology service other than CT scan.<br><br>$0 copay for each Medicare-covered retinal fundus service, Spirometry, and Peripheral Arterial Disease (PAD).<br><br>$25 copay for each Medicare-covered therapeutic radiology service.<br><br>Your cost share for medical supplies is based upon the provider of services.<br><br>$0 copay for continuous glucose meter supplies. |
| **Outpatient hospital observation**<br>Observation services are hospital outpatient services | Your cost share for Observation Care is based upon the services you receive. |

| Services that are covered for you | What you must pay when you get these services |
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| given to determine if you need to be admitted as an inpatient or can be discharged.<br><br>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.<br><br>**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.<br><br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-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. | |
| **Outpatient hospital services**<br>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br><br>Covered services include, but are not limited to:<br><br>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery<br>• Laboratory and diagnostic tests billed by the hospital<br>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it<br>• X-rays and other radiology services billed by the hospital<br>• Medical supplies such as splints and casts | $200 copay per facility visit.<br><br>Your cost share is based on:<br><br>• the tests, services, and supplies you receive<br>• the provider of the tests, services, and supplies<br>• the setting where the tests, services, and supplies are performed<br><br>$65 copay for each emergency room visit. Cost-sharing is waived if you are immediately admitted to the hospital.<br><br>$25 copay for each Medicare-covered diagnostic procedure and test.<br><br>$25 copay for each Medicare-covered lab service. |

| Services that are covered for you | What you must pay when you get these services |
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| • Certain drugs and biologicals that you can't give yourself<br><br>**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.<br><br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-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.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $0 copay for certain Medicare-covered lab services including Hemoglobin A1c, Urine Protein, Prothrombin (Protime), Urine Albumin, Fecal immunochemical test (FIT), Kidney Health Evaluation for members with Diabetes (KED), and COVID-19 testing.<br><br>$25 copay for each Medicare-covered diagnostic radiology and complex imaging service.<br><br>$25 copay for each Medicare-covered x-ray.<br><br>$25 copay for each Medicare-covered therapeutic radiology service.<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a psychiatrist (individual session).<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a psychiatrist (group session).<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a mental health professional other than a psychiatrist (individual session).<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a mental health professional other than a psychiatrist (group session).<br><br>$25 copay for each Medicare-covered partial hospitalization visit.<br><br>Your cost share for medical supplies is based upon the provider of services.<br><br>$0 copay for continuous glucose meter supplies.<br><br>$0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself. |

| Services that are covered for you | What you must pay when you get these services |
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| **Outpatient mental health care**<br>Covered services include:<br>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.<br><br>We also cover some telehealth visits with psychiatric and mental health professionals. See **"Physician/Practitioner services, including doctor's office visits**" for information about telehealth outpatient mental health care.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $25 copay for each Medicare-covered outpatient mental health service provided by a psychiatrist (individual session).<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a psychiatrist (group session).<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a mental health professional other than a psychiatrist (individual session).<br><br>$25 copay for each Medicare-covered outpatient mental health service provided by a mental health professional other than a psychiatrist (group session). |
| **Outpatient rehabilitation services**<br>Covered services include: physical therapy, occupational therapy, and speech language therapy.<br><br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $25 copay for each Medicare-covered physical or speech therapy visit.<br><br>$25 copay for each Medicare-covered occupational therapy visit. |
| **Outpatient substance abuse services**<br>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. | $25 copay for each Medicare-covered individual outpatient substance abuse session.<br><br>$25 copay for each Medicare-covered group outpatient substance abuse session. |

| Services that are covered for you | What you must pay when you get these services |
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| Covered services include:<br><br>• Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment<br>• Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br><br>**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."<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | Your cost share is based on:<br><br>• the tests, services, and supplies you receive<br>• the provider of the tests, services, and supplies<br>• the setting where the tests, services, and supplies are performed<br><br>$200 copay for each Medicare-covered outpatient surgery at a hospital outpatient facility.<br><br>$200 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center. |
| **Partial hospitalization services**<br>"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.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $25 copay for each Medicare-covered partial hospitalization visit. |
| **Physician/Practitioner services, including doctor's** | Your cost share is based on: |

| Services that are covered for you | What you must pay when you get these services |
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| **office visits**<br>Covered services include:<br><br>• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location<br>• Consultation, diagnosis, and treatment by a specialist<br>• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment<br>• Certain telehealth services, including:<br>◦ Primary care physician services<br>◦ Physician specialist services<br>◦ Mental health services (individual sessions)<br>◦ Mental health services (group sessions)<br>◦ Psychiatric services (individual sessions)<br>◦ Psychiatric services (group sessions)<br>◦ Urgently needed services<br>◦ Occupational therapy services<br>◦ Physical and speech therapy services<br>◦ Opioid treatment services<br>◦ Outpatient substance abuse services (individual sessions)<br>◦ Outpatient substance abuse services (group sessions)<br>◦ Kidney disease education services<br>◦ Diabetes self-management services<br>• Your plan also offers MDLive for behavioral telehealth services. You can schedule a telehealth visit through MDLive, which provides virtual access to board-certified psychiatrists and licensed therapists in all 50 states. These telehealth visits can be scheduled through the MDLive call center, web portal, or mobile app. The call center is available 24/7, 365 days per year. Visits can be scheduled or on demand. Call 1-888-865-0729 (available 24/7), TTY: 1-800-770-5531, visit mdlive.com/aetnamedicarebh, or access the MDLive mobile app. Due to provider licensing, members must be located within the United States and Puerto Rico when using MDLive services.<br>• This coverage is in addition to the telehealth services described below. For more details on your additional telehealth coverage, please review the | • the tests, services, and supplies you receive<br>• the provider of the tests, services, and supplies<br>• the setting where the tests, services, and supplies are performed<br><br>$15 copay for Medicare-covered primary care physician (PCP) services (including telehealth services and urgently needed services).<br><br>$25 copay for Medicare-covered physician specialist services (including surgery second opinion, telehealth services, home infusion professional services, and urgently needed services).<br><br>$25 copay for each Medicare-covered hearing exam.<br><br>Certain additional telehealth services, including those for:<br><br>• $15 copay for each primary care physician service<br><br>• $25 copay for each physician specialist service<br><br>• $25 copay for each mental health service (individual sessions)<br><br>• $25 copay for each mental health service (group sessions)<br><br>• $25 copay for each psychiatric service (individual sessions)<br><br>• $25 copay for each psychiatric service (group sessions)<br><br>• $50 copay for each urgently needed service<br><br>• $25 copay for each occupational therapy visit |

| Services that are covered for you | What you must pay when you get these services |
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| Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth.<br>◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. Not all providers offer telehealth services.<br>◦ You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc, MinuteClinic Video Visit, or other provider that offers telehealth services covered under your plan. Members can access Teladoc at Teladoc.com/Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711), available 24/7. **Note:** Teladoc is not currently available outside of the United States and its territories (Guam, Puerto Rico, and the U.S. Virgin Islands). You can find out if MinuteClinic Video Visits are available in your area at CVS.com/MinuteClinic/virtual-care/videovisit.<br>• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare<br>• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home<br>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location<br>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location<br>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>  • You have an in-person visit within 6 months prior to your first telehealth visit<br>  • You have an in-person visit every 12 months while receiving these telehealth services<br>  • Exceptions can be made to the above for certain circumstances | • $25 copay for each physical or speech therapy visit<br>• $25 copay for each opioid treatment program service<br>• $25 copay for each individual outpatient substance abuse service<br>• $25 copay for each group outpatient substance abuse service<br>• $0 copay for each kidney disease education service<br>• $0 copay for each diabetes self-management training service<br><br>$0 copay for each Teladoc telehealth service.<br><br>$0 copay for each mental health telehealth service provided by MDLive.<br><br>$25 copay for each Medicare-covered dental care service.<br><br>$25 copay for Medicare-covered allergy testing.<br><br>$15 copay for nationally contracted walk-in clinics. |

| Services that are covered for you | What you must pay when you get these services |
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| • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers<br>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:<br>◦ You're not a new patient **and**<br>◦ The check-in isn't related to an office visit in the past 7 days **and**<br>◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:<br>◦ You're not a new patient **and**<br>◦ The evaluation isn't related to an office visit in the past 7 days **and**<br>◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Consultation your doctor has with other doctors by phone, internet, or electronic health record<br>• Second opinion by another network provider prior to surgery<br>• 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)<br>• Allergy testing<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | |
| **Podiatry services**<br>Covered services include:<br><br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)<br>• Routine foot care for members with certain medical conditions affecting the lower limbs | $25 copay for each Medicare-covered podiatry service. |

| Services that are covered for you | What you must pay when you get these services |
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| **Prostate cancer screening exams**<br>For men age 50 and older, covered services include the following once every 12 months:<br>• Digital rectal exam<br>• Prostate Specific Antigen (PSA) test | There is no coinsurance, copayment, or deductible for an annual PSA test.<br><br>$0 copay for each Medicare covered digital rectal exam. |
| **Prosthetic devices and related supplies**<br>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.<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | 20% of the total cost for each Medicare-covered prosthetic device. |
| **Pulmonary rehabilitation services**<br>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. | $20 copay for each Medicare-covered pulmonary rehabilitation service. |
| **Resources for Living®**<br>Resources for Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life-related issues. Call Resources for Living at **1-866-370-4842**. | There is no coinsurance, copayment, or deductible for Resources for Living. |
| **Screening and counseling to reduce alcohol misuse**<br>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.<br><br>If you screen positive for alcohol misuse, you can get up | There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. |

| Services that are covered for you | What you must pay when you get these services |
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| 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. | |
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br>For qualified individuals, a LDCT is covered every 12 months.<br><br>**Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who 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.<br><br>*For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>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.<br><br>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. |
| **Services to treat kidney disease** | $0 copay for self-dialysis training. |

| Services that are covered for you | What you must pay when you get these services |
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| Covered services include:<br><br>• 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<br>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible)<br>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)<br>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)<br>• Home dialysis equipment and supplies<br>• 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)<br><br>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "**Medicare Part B prescription drugs**."<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | $0 copay for each Medicare-covered kidney disease education session.<br><br>$25 copay for in- and out-of-area outpatient dialysis.<br><br>See "**Inpatient hospital care**" for more information on inpatient services.<br><br>20% of the total cost for home dialysis equipment and supplies.<br><br>$0 copay for Medicare-covered home support services. |
| **Skilled nursing facility (SNF) care**<br>(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.")<br><br>Days covered: up to 100 days per benefit period. A prior hospital stay is not required.<br><br>Covered services include but are not limited to:<br><br>• Semiprivate room (or a private room if medically | $0 per day, days 1-20; $100 per day, days 21-100 for each Medicare-covered SNF stay.<br><br>A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row, including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| necessary)<br>• Meals, including special diets<br>• Skilled nursing services<br>• Physical therapy, occupational therapy, and speech therapy<br>• 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.)<br>• Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All components of blood are covered beginning with the first pint used.<br>• Medical and surgical supplies ordinarily provided by SNFs<br>• Laboratory tests ordinarily provided by SNFs<br>• X-rays and other radiology services ordinarily provided by SNFs<br>• Use of appliances such as wheelchairs ordinarily provided by SNFs<br>• Physician/Practitioner services<br><br>**Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.** | |
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>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.<br><br>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 cost-sharing. Each counseling attempt includes up to four face-to-face visits.<br><br>In addition to Medicare-covered benefits, we also offer: | There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.<br><br>$0 copay for each non-Medicare covered smoking and tobacco use cessation visit. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • Additional individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year | |
| **Supervised Exercise Therapy (SET)**<br>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.<br><br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<br><br>The SET program must:<br><br>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication<br>• Be conducted in a hospital outpatient setting or a physician's office<br>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD<br>• 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<br><br>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. | $20 copay for each Medicare-covered supervised exercise therapy service. |
| **Urgently needed services**<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary.<br>Coverage is available worldwide (i.e., outside of the United States). | $50 copay for each urgent care facility visit.<br><br>Cost-sharing is not waived if you are admitted to the hospital.<br><br>$50 copay for each urgent care telehealth service. |
| **Vision care**<br>Covered services include: | $25 copay for exams to diagnose and treat diseases and conditions of the eye. |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| • 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<br>• For people who are at high risk of glaucoma, we will cover one glaucoma screening every 12 months. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older<br>• For people with diabetes, screening for diabetic retinopathy is covered once per year<br>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)<br><br>In addition to Medicare-covered benefits, we also offer:<br><br>• Non-Medicare covered eye exams: one exam every year<br>• Follow-up diabetic eye exam | $0 copay for each Medicare-covered glaucoma screening.<br><br>$0 copay for one diabetic retinopathy screening.<br><br>$0 copay for each follow-up diabetic eye exam.<br><br>$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals.<br><br>$0 copay for each non-Medicare covered eye exam.<br><br>Additional cost-sharing may apply if you receive additional services during your visit. |
| **"Welcome to Medicare" preventive visit**<br>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.<br><br>**Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit. | There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.<br><br>$0 copay for a Medicare-covered EKG screening following the "Welcome to Medicare" preventive visit. |

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

# Prescription Drug Schedule of Cost Sharing

Former Employer/Union/Trust Name: **The Dow Chemical Company**
Group Agreement Effective Date: **01/01/2023**
Master Plan ID: **0000530, 0005687**

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

| | |
|---|---|
| **Annual Deductible Amount:** | $0 |
| **Formulary Type:** | Classic |
| **Number of Cost Share Tiers:** | 4 Tier |
| **Initial Coverage Limit:** | $4,660 |
| **True Out-of-Pocket Amount:** | $7,400 |
| **Maximum Out-of-Pocket Amount** | $3,100 |
| Once your individual out-of-pocket expenses reach this amount, you will pay $0 for all covered prescription drugs for the remainder of the plan year. | |
| **Retail Pharmacy Network:** | P1 |
| The name of your pharmacy network is listed above. The Aetna Medicare pharmacy network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost-sharing may be less at pharmacies with preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs.<br><br>The pharmacy network includes limited lower-cost, preferred pharmacies in **Suburban Arizona, Suburban Illinois, Urban Kansas, Suburban & Rural Michigan, Urban Michigan, Urban Missouri, Rural North Dakota, Suburban Utah, Suburban West Virginia, and Suburban Wyoming**. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. To find a network pharmacy, or find up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Member Services at the number on the back of your member ID card or consult the online *Pharmacy Directory* at Dow.AetnaMedicare.com.<br><br>Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays. | |

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

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

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

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

**Important Message About What You Pay for Insulin —** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

**Initial Coverage Stage:** Amount you pay, up to $4,660 in total covered prescription drug expenses.

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

| **Initial Coverage** | **One-Month Supply** | | | **Extended Supply** | |
|---|---|---|---|---|---|
| | **Standard retail cost-sharing (in-network)** (up to a 30-day supply) | **Long-term care (LTC) cost-sharing** (up to a 31-day supply) | **Out-of-network cost-sharing*** (up to a 30-day supply) | **Standard retail or standard mail order cost-sharing** (up to a 90-day supply) | **Preferred mail order cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic drugs - Includes low-cost generic drugs | You pay $5 | You pay $5 | You pay $5 | You pay $15 | You pay $10 |
| **Tier 2** Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs | You pay $30 | You pay $30 | You pay $30 | You pay $90 | You pay $60 |
| **Tier 3** Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs | You pay $50 | You pay $50 | You pay $50 | You pay $150 | You pay $100 |

| 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 4** Specialty drugs - Includes high-cost/unique brand and generic drugs | You pay 33% for your drug | You pay 33% for your drug | You pay 33% for your drug | Limited to one-month supply | Limited to one-month supply |

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

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

| Initial Coverage | One-Month Supply | | | Extended Supply | |
|---|---|---|---|---|---|
| | **Preferred retail cost-sharing (in-network)** (up to a 30-day supply) | **Long-term care (LTC) cost-sharing** (up to a 31-day supply) | **Out-of-network cost-sharing*** (up to a 30-day supply) | **Preferred retail cost-sharing** (up to a 90-day supply) | **Preferred mail order cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic drugs - Includes low-cost generic drugs | You pay $5 | You pay $5 | You pay $5 | You pay $10 | You pay $10 |
| **Tier 2** Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs | You pay $30 | You pay $30 | You pay $30 | You pay $60 | You pay $60 |
| **Tier 3** Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs | You pay $50 | You pay $50 | You pay $50 | You pay $100 | You pay $100 |
| **Tier 4** Specialty drugs - Includes high-cost/unique brand and generic drugs | You pay 33% for your drug | You pay 33% for your drug | You pay 33% for your drug | Limited to one-month supply | Limited to one-month supply |

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

**Coverage Gap Stage**: Amount you pay after you reach $4,660 in total covered prescription drug expenses and until you reach $7,400 in out-of-pocket covered prescription drug costs. Your plan's gap coverage is listed in the chart below.

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

| 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 - Includes low-cost generic drugs | You pay $5 | You pay $5 | You pay $5 | You pay $15 | You pay $10 |
| **Tier 2** Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug |
| **Tier 3** Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug |
| **Tier 4** Specialty drugs - Includes high-cost/unique brand and generic drugs | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | Limited to one-month supply | Limited to one-month supply |

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

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

| Gap Coverage | One-Month Supply | | | Extended Supply | |
|---|---|---|---|---|---|
| | **Preferred retail cost-sharing (in-network)** (up to a 30-day supply) | **Long-term care (LTC) cost-sharing** (up to a 31-day supply) | **Out-of-network cost-sharing*** (up to a 30-day supply) | **Preferred retail cost-sharing** (up to a 90-day supply) | **Preferred mail order cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic drugs - Includes low-cost generic drugs | You pay $5 | You pay $5 | You pay $5 | You pay $10 | You pay $10 |
| **Tier 2** Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug |
| **Tier 3** Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug |
| **Tier 4** Specialty drugs - Includes high-cost/unique brand and generic drugs | You pay 25% for your drug | You pay 25% for your drug | You pay 25% for your drug | Limited to one-month supply | Limited to one-month supply |

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

Your former employer/union/trust provides some additional coverage during the Coverage Gap stage for covered drugs. Your cost share appears in the chart above.

For brand drugs not included in the additional coverage provided by your former employer/union/trust, the Medicare Coverage Gap Discount Program applies. The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic

drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2023, that amount is $7,400.

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

**Catastrophic Coverage Stage:** Amount you pay for covered prescription drugs after reaching $7,400 in out-of-pocket prescription drug costs.

| Prescription Drug Quantity | All covered prescription drugs |
|---|---|
| Per prescription or refill | You pay $0<br><br>We will pay the rest. |

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

**This Plan Uses the Classic Formulary:**
Your plan uses the Classic formulary, which means that only drugs on Aetna's Drug List will be covered under your plan as long as the drug is medically necessary, and the plan rules are followed. Tiers labeled as brand, preferred brand, and non-preferred drug will also include some high-cost generic drugs. Non-preferred copayment levels may apply to some drugs on the Drug List. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2023 Group Formulary (List of Covered Drugs)* for more information.

**Non-Part D Supplemental Benefit**

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

- Drugs when used for the relief of cough or cold symptoms
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for weight loss
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Drugs when used for the treatment of erectile dysfunction

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

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

To find the drugs that are covered under this supplemental benefit, go online to: AetnaMedicare.com/SupplementalBenefitMAPD. This document will also show limitations, such as quantity limits and prior authorization requirements. For more information, call Member Services.

## Aetna Medicare Plan (PPO) Member Services

| Method | Member Services – Contact Information |
|---|---|
| **CALL**  | The number on your member ID card or 1-855-344-2209<br>Calls to this number are free.<br>Hours of operation are 8 AM to 9 PM ET, Monday through Friday<br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY**  | 711<br>Calls to this number are free.<br>Hours of operation are 8 AM to 9 PM ET, Monday through Friday |
| **WRITE**  | Aetna Medicare<br>PO Box 7082<br>London, KY 40742 |
| **WEBSITE**  | Dow.AetnaMedicare.com. |

### State Health Insurance Assistance Program (SHIP)

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

***PRA Disclosure Statement*** *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

# Multi-Language Insert
# Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-344-2209. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-344-2209. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-344-2209。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-344-2209。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-344-2209. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-344-2209. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-344-2209. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-344-2209. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-344-2209. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-344-2209. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-344-2209 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-344-2209. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-344-2209. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-344-2209. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-344-2209. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-344-2209. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-344-2209. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

**Hawaiian:** He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-855-344-2209. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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