Aetna Medicare

Former Employer/Union/Trust Name: **Parkway School District**
Group Agreement Effective Date: **01/01/2025**
Master Plan ID: **0014142**

This *Schedule of Cost Sharing* is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the document with information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.) If you have questions, please call our Member Services at the telephone number printed on your member ID card or call our general Member Services at 1-888-267-2637. (TTY users should call 711.) Hours are 8 AM to 9 PM ET, Monday through Friday.

Annual Deductible	**FOR SERVICES RECEIVED IN-NETWORK**	**FOR SERVICES RECEIVED IN-NETWORK & OUT-OF-NETWORK COMBINED**
This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered Medicare Part A and B services.	**No Deductible**	**No Deductible**
Annual Maximum Out-of-Pocket Limit	**FOR SERVICES RECEIVED IN-NETWORK**	**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). The amounts you pay for covered services received from network and out-of-network providers count toward the in-network maximum out-of-pocket amount.	**$4,150**	**$6,200**

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

If you receive services from:	If your plan services include:	You will pay:
A primary care provider (PCP): • Family Practitioner • Internal Medicine • General Practitioner • Geriatrician • Physician Assistants (Not available in all states) • Nurse Practitioners (Not available in all states) If you receive 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 you receive more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

Medical Benefits Chart

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

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

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Acupuncture for chronic low back pain (*continued*)		
school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		
Ambulance services • Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care 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. • If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. **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.**	$100 copay for each Medicare-covered one-way trip via ground or air ambulance. Ground or air ambulance cost sharing is not waived if you are admitted to the hospital.	25% of the total cost for each Medicare-covered one-way trip via ground or air ambulance. Ground or air ambulance cost sharing is not waived if you are admitted to the hospital.
Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and	$0 copay for an annual routine physical exam.	25% of the total cost for an annual routine physical exam.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Annual routine physical (*continued*) lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to Medicare preventive visit. You may schedule your annual routine physical once each calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. (See **Outpatient diagnostic tests and therapeutic services and supplies** for more information.)		
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. Our plan will cover the annual wellness visit once each calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	25% of the total cost for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	25% of the total cost for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women aged 40 and older	There is no coinsurance, copayment, or deductible for covered screening mammograms. $0 copay for each diagnostic mammogram.	25% of the total cost for covered screening mammograms. 25% of the total cost for each diagnostic mammogram.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Breast cancer screening (mammograms) (*continued*) • Clinical breast exams once every 24 months **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.**		
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	20% of the total cost for each Medicare-covered cardiac rehabilitation visit. 20% of the total cost for each Medicare-covered intensive cardiac rehabilitation visit.	25% of the total cost for each Medicare-covered cardiac rehabilitation visit. 25% of the total cost for each Medicare-covered intensive cardiac rehabilitation visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	25% of the total cost for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	25% of the total cost for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal 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.	25% of the total cost for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: *This service is continued on the next page*	$20 copay for each Medicare-covered chiropractic visit.	25% of the total cost for each Medicare-covered chiropractic visit.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Chiropractic services (*continued*) • We cover only manual manipulation of the spine to correct subluxation **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Colorectal cancer screening The following tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Twice per calendar year. • Screening Guaiac-based fecal occult blood test (gFOBT) for patients 45 years and older. Twice per calendar year. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk *This service is continued on the next page*	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy. $0 copay for each Medicare-covered barium enema. Diagnostic colonoscopy: $0 copay Please note: If a polyp is removed or a biopsy is performed during a Medicare-covered screening or diagnostic colonoscopy, the polyp removal and associated pathology will be covered at $0 copay.	25% of the total cost for a Medicare-covered colorectal cancer screening exam. This is also known as a preventive colonoscopy. 25% of the total cost for each Medicare-covered barium enema. Diagnostic colonoscopy is subject to the **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** cost-sharing amount. 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. Please note: 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 subject to the outpatient surgery cost

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Colorectal cancer screening (*continued*) and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.		sharing. (See **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** for more information.)
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. **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.	25% of the total cost for each Medicare-covered dental care service.
Dental services (additional) **Preventive dental services:** Covered services include: • Oral exams: ◦ Periodic/comprehensive: Two per calendar year ◦ Problem-focused/periodontal: Two per calendar year • Cleanings (Prophylaxis): Two per calendar year • Bitewing x-rays: One set per calendar year • Complete (full mouth) series x-rays, panoramic, or vertical bitewing x-rays: One set every three calendar years • Periapical x-rays: No frequency limitations **Exclusions and limitations:** *This service is continued on the next page*	Cost-sharing for covered preventive dental services*: • You have a $0 dental deductible. • You pay 0% coinsurance for each covered dental service. Coverage is subject to any plan benefit limitations.	Cost-sharing for covered preventive dental services*: • After you pay your $75 out-of-network dental deductible, you pay 30% coinsurance for each covered dental service. Coverage is subject to any plan benefit limitations.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Dental services (additional) (*continued*) • Frequency limitations may apply to covered services. **Annual benefit maximum*:** We pay up to $750 each year for the non-Medicare covered preventive dental services described above. **Dental plan name:** Aetna Enhanced Preventive Dental Value PPO ***Amounts you pay for preventive dental services do not apply to your In-Network or Combined Out-of-Pocket Maximum.***		
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	25% of the total cost for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	25% of the total cost for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe *This service is continued on the next page*	$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. $0 copay for each pair of Medicare-covered diabetic shoes and inserts.	25% of the total cost for each Medicare-covered supply to monitor blood glucose from OneTouch/LifeScan, or from a non-preferred provider when a prior authorization is received. 25% of the total cost for each pair of Medicare-covered diabetic shoes and

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Diabetes self-management training, diabetic services and supplies (*continued*) diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • We exclusively cover OneTouch/LifeScan blood glucose monitors and test strips as our preferred diabetic supplies. Non-LifeScan monitors, and test strips may be covered if medically necessary, such as large font or talking meters for the visually impaired. You or your provider can request a medical exception, as a prior authorization is required. • Beginning January 2025, you must obtain your LifeScan blood glucose meter and other testing supplies (lancing devices, lancets and test strips) directly from a network pharmacy which requires a prescription from your provider. • Per CMS, some diabetic supplies under our exclusive partnership with LifeScan are covered under your medical coverage and will have a $0 copay. Other diabetic supplies are not available through LifeScan and are covered under your prescription drug coverages at cost-shares determined by the formulary tier they reside. LifeScan diabetic supplies covered under your medical coverage such as meters and test strips are available at network pharmacies for $0 cost share. Diabetic supplies covered under your prescription drug coverage (alcohol swabs, lancets, 2x2 gauze, needles and syringes) can be found on your plan's formulary guide. • Continuous glucose monitors (CGMs) are considered durable medical equipment (DME) and are subject to applicable DME *This service is continued on the next page*	$0 copay for Medicare-covered diabetes self-management training. 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.	inserts. 25% of the total cost for Medicare-covered diabetes self-management training. 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.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Diabetes self-management training, diabetic services and supplies (*continued*) cost sharing. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Durable medical equipment (DME) and related supplies Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Continuous glucose monitors (CGMs) and supplies are available through participating DME providers. For a list of DME providers, visit www.aetna.com/dsepublicContent/assets/pdf/en/DME_National_Provider_Listing.pdf. Dexcom and FreeStyle Libre continuous glucose monitors and supplies are also available at participating pharmacies. Your provider **must** obtain authorization for a continuous glucose monitor. Sensors can be obtained without prior authorization from the plan. 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 participating pharmacies and suppliers is available on our website at: AetnaRetireePlans.com. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	20% of the total cost for each Medicare-covered durable medical equipment item. $0 copay for continuous glucose monitors.	25% of the total cost for each Medicare-covered durable medical equipment item.
Emergency care Emergency care refers to services that are: *This service is continued on the next page*	$50 copay for each emergency room visit.	$50 copay for each emergency room visit.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Emergency care (*continued*) • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. This coverage is available worldwide (i.e., outside of the United States). In addition to Medicare-covered benefits, we also offer: • Emergency care (worldwide) • Emergency ambulance services (worldwide) You may have to pay the provider at the time of service and submit for reimbursement.	Cost sharing is waived if you are immediately admitted to the hospital. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized. $50 copay for each emergency room visit worldwide (i.e., outside the United States). Cost sharing is waived if you are admitted to the hospital. $100 copay for each one-way trip via ground or air ambulance worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.	Cost sharing is waived if you are immediately admitted to the hospital. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized. $50 copay for each emergency room visit worldwide (i.e., outside the United States). Cost sharing is waived if you are admitted to the hospital. $100 copay for each one-way trip via ground or air ambulance worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.
Fitness program (physical fitness) You are covered for a basic membership to any SilverSneakers® participating fitness facility. If you do not reside near a participating facility, or prefer to exercise at home, online classes and *This service is continued on the next page*	$0 copay for health club membership/fitness classes.	$0 copay for at-home fitness kits ordered through SilverSneakers. There are no out-of-network facilities available for this benefit.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Fitness program (physical fitness) (*continued*) at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers. 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. To get started, you will need your SilverSneakers ID number. Please visit SilverSneakers.com or call SilverSneakers at 1-855-627-3795 (TTY: 711) to obtain this ID number. Then, bring this ID number with you when you visit a participating fitness facility. Information about participating facilities can be found by using the SilverSneakers website or by calling SilverSneakers.		
Health and wellness education programs • **24-Hour Nurse Line:** You can talk to a registered nurse 24 hours a day, 7 days a week on the 24/7 Nurse Line. They can help with health-related questions when your doctor is not available. Call **1-855-493-7019** (TTY: 711). The registered nurse staff cannot diagnose, prescribe or give medical advice. If you need urgent or emergency care, call 911 and/or your doctor immediately. • **Health education:** You can meet with a certified health educator or other qualified health professional to learn about health and wellness topics like: diabetes management, nutrition counseling, asthma education, and more. You have the option to meet one-on-one, in a group, or virtually. Ask your provider for information on how these services may help you.	There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line benefit. Health education is included in your plan.	The in-network provider must be used for the 24-Hour Nurse Line benefit. Health education is included in your plan.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient	$25 copay for each Medicare-covered hearing exam.	25% of the total cost for each Medicare-covered hearing exam.
This service is continued on the next page	$25 copay for each	25% of the total cost for

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

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Home health agency care (*continued*) Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	health visit. 20% of the total cost for each Medicare-covered durable medical equipment item.	home health visit. 25% of the total cost for each Medicare-covered durable medical equipment item.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan. Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit *This service is continued on the next page*	You will pay the cost sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. (See **Physician/Practitioner services, including doctor's office visits** or **Home health agency care** for any applicable cost sharing.) Please note that home infusion drugs, pumps, and devices provided	You will pay the cost sharing that applies to primary care physician services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. (See **Physician/Practitioner Services, Including Doctor's Office Visits** or **Home Health Agency Care** for any applicable cost sharing.) Please note that home infusion drugs, pumps, and devices provided

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Home infusion therapy (*continued*) • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	during a home infusion therapy visit are covered separately under your **Durable medical equipment (DME) and related supplies** benefit.	during a home infusion therapy visit are covered separately under your **Durable medical equipment (DME) and related supplies** benefit.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. 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. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care 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. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> 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. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis</u>: If you need non-emergency, non-urgently needed services that are covered	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. Hospice consultations are included as part of inpatient hospital care. Physician service cost sharing may apply for outpatient consultations.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Hospice care (*continued*) under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services For services that are covered by 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. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal 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.* **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, *This service is continued on the next page*	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. 20% of the total cost for other Medicare-covered	$0 copay for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. 25% of the total cost for other Medicare-covered Part B vaccines.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Immunizations (*continued*) with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	Part B vaccines. You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated.	You may have to pay an office visit cost share if you get other services at the same time that you get vaccinated.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and	For each inpatient hospital stay, you pay: $300 per day, days 1-5; $0 unlimited additional days. Cost sharing is charged for each medically necessary covered inpatient stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.	For each inpatient hospital stay, you pay: 25% per stay. Cost sharing is charged for each medically necessary covered inpatient stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Inpatient hospital care (*continued*) intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. 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. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization rules may apply for network** *This service is continued on the next page*		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Inpatient hospital care (*continued*) **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 Covered services include mental health care services that require a hospital stay. Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	For each inpatient stay, you pay: $300 per day, days 1-5; $0 unlimited additional days. Cost sharing is charged for each medically necessary covered inpatient stay.	For each inpatient stay, you pay: 25% per stay. Cost sharing is charged for each medically necessary covered inpatient stay.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your skilled nursing facility 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). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including *This service is continued on the next page*	$10 copay for Medicare-covered primary care physician (PCP) services. $25 copay for Medicare-covered specialist services. 20% of the total cost for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered lab service. 20% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service. $15 copay for each Medicare-covered x-ray. 20% of the total cost for each Medicare-covered therapeutic radiology service.	25% of the total cost for Medicare-covered primary care physician (PCP) services. 25% of the total cost for Medicare-covered specialist services. 25% of the total cost for each Medicare-covered diagnostic procedure and test. 25% of the total cost for each Medicare-covered lab service. 25% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service. 25% of the total cost for each Medicare-covered x-ray. 25% of the total cost for each Medicare-covered

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (*continued*)	Your cost share for medical supplies is based upon the provider of services. $0 copay for continuous glucose meter supplies. 20% of the total cost for each Medicare-covered prosthetic and orthotic device. 20% of the total cost for each Medicare-covered physical or speech therapy visit. 20% of the total cost for each Medicare-covered occupational therapy visit.	therapeutic radiology service. Your cost share for medical supplies is based upon the provider of services. 25% of the total cost for each Medicare-covered prosthetic and orthotic device. 25% of the total cost for each Medicare-covered physical or speech therapy visit. 25% of the total cost for each Medicare-covered occupational therapy visit.
adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	25% of the total cost for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical	There is no coinsurance, copayment, or deductible for the MDPP benefit.	$0 copay for the Medicare-covered MDPP benefit.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Medicare Diabetes Prevention Program (MDPP) (*continued*) activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.		
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot	Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin, and plan level deductibles do not apply. 20% of the total cost per prescription or refill. 20% of the total cost per chemotherapy or infusion therapy Part B drug. $25 copay for the administration of the chemotherapy drug as well as for infusion therapy. 20% of the total cost 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. 20% up to $35 copay per insulin Part B drug. Part B drugs may be subject to Step Therapy requirements.	Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin, and plan level deductibles do not apply. 25% of the total cost per prescription or refill. 25% of the total cost per chemotherapy or infusion therapy Part B drug. 25% of the total cost for the administration of the chemotherapy drug as well as for infusion therapy. 25% of the total cost 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. 20% up to $35 copay per insulin Part B drug. Part B drugs may be subject to Step Therapy requirements.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Medicare Part B prescription drugs (*continued*)		
self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) • Allergy shots The following link will take you to a list of Part B Drugs that may be subject to Step Therapy:		
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Medicare Part B prescription drugs (*continued*)		
Aetna.com/partb-step. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 of the *Evidence of Coverage*. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	25% of the total cost for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments **Prior authorization rules may apply for network services. Your network provider is responsible**	$20 copay for each Medicare-covered opioid use disorder treatment service.	25% of the total cost for each Medicare-covered opioid use disorder treatment service.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Opioid treatment program services (*continued*)		
for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.		
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. 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. • Other outpatient diagnostic tests **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided $15 copay for each Medicare-covered x-ray. 20% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service. $0 copay for each Medicare-covered lab service. $0 copay for Medicare-covered blood services. 20% of the total cost for each Medicare-covered diagnostic procedure and test. 20% of the total cost for each Medicare-covered CT scan. 20% of the total cost for each Medicare-covered diagnostic service other than CT scan. $0 copay for each Medicare-covered retinal	Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided 25% of the total cost for each Medicare-covered x-ray. 25% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service. 25% of the total cost for each Medicare-covered lab service. 25% of the total cost for Medicare-covered blood services. 25% of the total cost for each Medicare-covered diagnostic procedure and test. 25% of the total cost for each Medicare-covered CT scan. 25% of the total cost for each Medicare-covered diagnostic service other than CT scan. 25% of the total cost for

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
	fundus service, spirometry, and peripheral arterial disease (PAD). 20% of the total cost for each Medicare-covered therapeutic radiology service. Your cost share for medical supplies is based upon the provider of services. $0 copay for continuous glucose meter supplies.	each Medicare-covered therapeutic radiology service. Your cost share for medical supplies is based upon the provider of services.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users *This service is continued on the next page*	Your cost share for Observation Care is based upon the services you receive.	Your cost share for Observation Care is based upon the services you receive.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Outpatient hospital observation (*continued*) call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$250 copay per facility visit. Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided $50 copay for each emergency room visit. Cost sharing is waived if you are immediately admitted to the hospital. 20% of the total cost for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered lab service. 20% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service. $15 copay for each Medicare-covered x-ray. 20% of the total cost for each Medicare-covered therapeutic radiology service. $25 copay for each	25% of the total cost of the facility visit. Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided $50 copay for each emergency room visit. Cost sharing is waived if you are immediately admitted to the hospital. 25% of the total cost for each Medicare-covered diagnostic procedure and test. 25% of the total cost for each Medicare-covered lab service. 25% of the total cost for each Medicare-covered diagnostic radiology and complex imaging service. 25% of the total cost for each Medicare-covered x-ray. 25% of the total cost for each Medicare-covered therapeutic radiology service.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
	Medicare-covered individual session for outpatient psychiatrist services. $20 copay for each Medicare-covered group session for outpatient psychiatrist services. $25 copay for each Medicare-covered individual session for outpatient mental health services. $20 copay for each Medicare-covered group session for outpatient mental health services. $25 copay for each Medicare-covered partial hospitalization visit or intensive outpatient visit. Your cost share for medical supplies is based upon the provider of services. $0 copay for continuous glucose meter supplies. 20% of the total cost per prescription or refill for certain drugs and biologicals that you can't give yourself.	25% of the total cost for each Medicare-covered individual session for outpatient psychiatrist services. 25% of the total cost for each Medicare-covered group session for outpatient psychiatrist services. 25% of the total cost for each Medicare-covered individual session for outpatient mental health services. 25% of the total cost for each Medicare-covered group session for outpatient mental health services. 25% of the total cost for each Medicare-covered partial hospitalization visit or intensive outpatient visit. Your cost share for medical supplies is based upon the provider of services. 25% of the total cost per prescription or refill for certain drugs and biologicals that you can't give yourself.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), *This service is continued on the next page*	$25 copay for each Medicare-covered individual session for outpatient psychiatrist services. $20 copay for each Medicare-covered group	25% of the total cost for each Medicare-covered individual session for outpatient psychiatrist services. 25% of the total cost for each Medicare-covered

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Outpatient mental health care (*continued*)	session for outpatient psychiatrist services. $25 copay for each Medicare-covered individual session for outpatient mental health services. $20 copay for each Medicare-covered group session for outpatient mental health services.	group session for outpatient psychiatrist services. 25% of the total cost for each Medicare-covered individual session for outpatient mental health services. 25% of the total cost for each Medicare-covered group session for outpatient mental health services.
nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. We also cover some telehealth visits with psychiatric and mental health professionals. See **Physician/Practitioner services, including doctor's office visits** for information about telehealth outpatient mental health care. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	20% of the total cost for each Medicare-covered physical or speech therapy visit. 20% of the total cost for each Medicare-covered occupational therapy visit.	25% of the total cost for each Medicare-covered physical or speech therapy visit. 25% of the total cost for each Medicare-covered occupational therapy visit.
Outpatient substance use disorder services Our coverage is the same as Original Medicare, which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment	$25 copay for each Medicare-covered individual outpatient substance use disorder service. $20 copay for each Medicare-covered group outpatient substance use disorder service.	25% of the total cost for each Medicare-covered individual outpatient substance use disorder service. 25% of the total cost for each Medicare-covered group outpatient substance use disorder service.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Outpatient substance use disorder services (*continued*)		
• Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided $250 copay for each Medicare-covered outpatient surgery at a hospital outpatient facility. $250 copay for each Medicare-covered outpatient surgery at an ambulatory surgical center.	Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided 25% of the total cost for each Medicare-covered outpatient surgery at a hospital outpatient facility. 25% of the total cost for each Medicare-covered outpatient surgery at an ambulatory surgical center.
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	$25 copay for each Medicare-covered partial hospitalization visit or intensive outpatient visit.	25% of the total cost for each Medicare-covered partial hospitalization visit or intensive outpatient visit.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Partial hospitalization services and Intensive outpatient services (*continued*) *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. **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.**		
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: ◦ Primary care physician services ◦ Physician specialist services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services ◦ Occupational therapy services ◦ Physical and speech therapy services ◦ Opioid treatment services	Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided $10 copay for Medicare-covered primary care physician (PCP) services (including urgently needed services). $25 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). Your cost share for	Your cost share is based on: • the tests, services, and supplies you receive • the provider of the tests, services, and supplies • the setting where the tests, services, and supplies are performed/provided 25% of the total cost for Medicare-covered primary care physician (PCP) services (including urgently needed services). 25% of the total cost for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). Your cost share for
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Physician/Practitioner services, including doctor's office visits (*continued*) ◦ Outpatient substance use disorder services (individual sessions) ◦ Outpatient substance use disorder services (group sessions) ◦ Kidney disease education services ◦ Diabetes self-management services • For more details on your additional telehealth coverage, please review the Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. Not all providers offer telehealth services. ◦ You should contact your doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc™, MinuteClinic Video Visit, or other provider that offers telehealth services covered under your plan. Members can access Teladoc at Teladoc.com/Aetna or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711), available 24/7. **Note:** Teladoc is not currently available outside of the United States and its territories (Guam, Puerto Rico, and the U.S. Virgin Islands). You can find out if MinuteClinic Video Visits are available in your area at CVS.com/MinuteClinic/virtual-care/videovisit. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage *This service is continued on the next page*	cancer-related treatment is based upon the services you receive. $25 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including those for: • $10 copay for each primary care physician service • $25 copay for each physician specialist service • $20 copay for each mental health service (individual sessions) • $20 copay for each mental health service (group sessions) • $20 copay for each psychiatric service (individual sessions) • $20 copay for each psychiatric service (group sessions) • $50 copay for each urgently needed service • 20% of the total cost for each occupational therapy visit • 20% of the total cost for each	cancer-related treatment is based upon the services you receive. 25% of the total cost for each Medicare-covered hearing exam. Certain additional telehealth services, including those for: • 25% of the total cost for each primary care physician service • 25% of the total cost for each specialist physician service • 25% of the total cost for each mental health service (individual sessions) • 25% of the total cost for each mental health service (group sessions) • 25% of the total cost for each psychiatric service (individual sessions) • 25% of the total cost for each psychiatric service (group sessions) • $50 copay for each urgently needed service • 25% of the total

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network

Physician/Practitioner services, including doctor's office visits (*continued*)
 	
renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  • You have an in-person visit within 6 months prior to your first telehealth visit
  • You have an in-person visit every 12 months while receiving these telehealth services
  • Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ◦ You're not a new patient **and**
  ◦ The check-in isn't related to an office visit in the past 7 days **and**
  ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  ◦ You're not a new patient **and**
  ◦ The evaluation isn't related to an office visit in the past 7 days **and**
  ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic
 	
This service is continued on the next page
	physical and speech therapy visit
	• $20 copay for each opioid treatment program service
	• $25 copay for each individual outpatient substance use disorder service
	• $20 copay for each group outpatient substance use disorder service
	• $0 copay for each kidney disease education service
	• $0 copay for each diabetes self-management training service
	
	$0 copay for each Teladoc telehealth service.
	
	$25 copay for each Medicare-covered dental care service.
	
	$25 copay for Medicare-covered allergy testing.
	
	$10 copay for nationally contracted walk-in clinics.
		cost for each occupational therapy visit
		• 25% of the total cost for each physical and speech therapy visit
		• 25% of the total cost for each opioid treatment program service
		• 25% of the total cost for each individual outpatient substance use disorder service
		• 25% of the total cost for each group outpatient substance use disorder service
		• 25% of the total cost for each kidney disease education service
		• 25% of the total cost for each diabetes self-management training service
		
		25% of the total cost for each Medicare-covered dental care service.
		
		25% of the total cost for Medicare-covered allergy testing.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Physician/Practitioner services, including doctor's office visits (*continued*)		
health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Allergy testing • Diagnosis, consultation and the treatment of cancer **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$25 copay for each Medicare-covered podiatry service.	25% of the total cost for each Medicare-covered podiatry service.
Podiatry services (additional) The reduction of nails, including mycotic nails, and the removal of corns and calluses. In addition to Medicare-covered benefits, we also offer: • Additional non-Medicare covered podiatry services: up to twenty four visits every year	$25 copay for each non-Medicare covered podiatry service.	25% of the total cost for each non-Medicare covered podiatry service.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months:	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for each Medicare-covered digital	25% of the total cost for an annual PSA test. 25% of the total cost for each Medicare-covered digital rectal exam.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Prostate cancer screening exams (*continued*) • Digital rectal exam • Prostate Specific Antigen (PSA) test	rectal exam.	
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision care** later in this section for more detail. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	20% of the total cost for each Medicare-covered prosthetic and orthotic device.	25% of the total cost for each Medicare-covered prosthetic and orthotic device.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	20% of the total cost for each Medicare-covered pulmonary rehabilitation service.	25% of the total cost for each Medicare-covered pulmonary rehabilitation service.
Resources for Living® Resources for Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life-related issues. Call Resources for Living at 1-866-370-4842.	There is no coinsurance, copayment, or deductible for Resources for Living.	Resources for Living is included in your plan.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults *This service is continued on the next page*	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling	25% of the total cost for the Medicare-covered screening and counseling to reduce alcohol misuse

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Screening and counseling to reduce alcohol misuse (*continued*)	to reduce alcohol misuse preventive benefit.	preventive benefit.
with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.		
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 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 an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for 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.	25% of the total cost for the Medicare-covered counseling and shared decision making visit and for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	25% of the total cost for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (*continued*) We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.		
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, **Medicare Part B prescription drugs**. **Prior authorization rules may apply for network** *This service is continued on the next page*	$0 copay for self-dialysis training. $0 copay for each Medicare-covered kidney disease education session. 20% of the total cost for in- and out-of-area outpatient dialysis. For each inpatient hospital stay, you pay: $300 per day, days 1-5; $0 unlimited additional days. Cost sharing is charged for each medically necessary covered inpatient stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. 20% of the total cost for home dialysis equipment and supplies. $0 copay for	25% of the total cost for self-dialysis training. 25% of the total cost for each Medicare-covered kidney disease education session. 20% of the total cost for in- and out-of-area outpatient dialysis. See **Inpatient hospital care** for more information on inpatient services. 25% of the total cost for home dialysis equipment and supplies. 25% of the total cost for Medicare-covered home support services.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Services to treat kidney disease (*continued*)	Medicare-covered home support services.	
services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.		
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see the final chapter ("Definitions of important words") of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called SNFs.) Days covered: up to 100 days per benefit period. A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. 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. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	$0 per day, days 1-20; $40 per day, days 21-50; $0 per day, days 51-100 for each Medicare-covered SNF stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row, including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	25% per day, days 1-100 for each Medicare-covered SNF stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Skilled nursing facility (SNF) care (*continued*) • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**		
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. In addition to Medicare-covered benefits, we also offer: • Additional (non-Medicare covered) individual and group face-to-face intermediate and intensive counseling sessions: unlimited visits every year	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. $0 copay for each additional non-Medicare covered smoking and tobacco use cessation visit.	25% of the total cost for the Medicare-covered smoking and tobacco use cessation preventive benefits. 25% of the total cost for each additional non-Medicare covered smoking and tobacco use cessation visit.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.	20% of the total cost for each Medicare-covered Supervised Exercise Therapy service.	25% of the total cost for each Medicare-covered Supervised Exercise Therapy service.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Supervised Exercise Therapy (SET) (*continued*)		
Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. In addition to Medicare-covered benefits, we also offer:	$50 copay for each urgent care facility visit. Cost sharing is not waived if you are admitted to the hospital. $50 copay for each urgent care facility visit worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.	$50 copay for each urgent care facility visit. Cost sharing is not waived if you are admitted to the hospital. $50 copay for each urgent care facility visit worldwide (i.e., outside the United States). Cost sharing is not waived if you are admitted to the hospital.
This service is continued on the next page		

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Urgently needed services (continued) • Urgent care (worldwide) You may have to pay the provider at the time of service and submit for reimbursement.		
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening every 12 months. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) In addition to Medicare-covered benefits, we also offer: • Non-Medicare covered eye exams: one exam every year • Follow-up diabetic eye exam	$25 copay for exams to diagnose and treat diseases and conditions of the eye. $0 copay for each Medicare-covered glaucoma screening. $0 copay for one diabetic retinopathy screening. $0 copay for each follow-up diabetic eye exam. $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses, traditional lenses, bifocals, trifocals, progressive lenses, or contact lenses. Designer frames are excluded. $25 copay for each non-Medicare covered eye exam. Additional cost sharing may apply if you receive additional services during your visit.	25% of the total cost for exams to diagnose and treat diseases and conditions of the eye. 25% of the total cost for each Medicare-covered glaucoma screening. 25% of the total cost for one diabetic retinopathy screening. 25% of the total cost for each follow-up diabetic eye exam. $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses, traditional lenses, bifocals, trifocals, progressive lenses, or contact lenses. Designer frames are excluded. 25% of the total cost for each non-Medicare covered eye exam. Additional cost sharing may apply if you receive additional services during your visit.
Vision care – eyewear reimbursement (non-Medicare covered) Non-Medicare covered prescription eyewear includes: *This service is continued on the next page*	Our plan will reimburse you up to: $100 once every 24 months towards the cost of eyewear. You may be required to pay for services up front and submit for reimbursement.	

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Vision care – eyewear reimbursement (non-Medicare covered) (continued) • Contact lenses • Eyeglass prescription lenses • Eyeglass frames You may see any licensed vision provider in the U.S. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment. If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing information, which will delay the processing time. **Notes:** • If you use a non-licensed provider, you will not receive reimbursement. • You are responsible for any charges above the reimbursement amount. • Eyewear reimbursement excludes eyeglasses or contact lenses after cataract surgery. ***** *Amounts you pay for non-Medicare covered eyewear do not apply to your In-Network or Combined Out-of-Pocket Maximum.*		
Welcome to Medicare preventive visit The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. $0 copay for a Medicare-covered EKG screening following the Welcome to Medicare preventive visit.	25% of the total cost for the Welcome to Medicare preventive visit. 25% of the total cost for a Medicare-covered EKG screening following the Welcome to Medicare preventive visit.

Services that are covered for you	What you must pay when you get these services in-network	What you must pay when you get these services out-of-network
Wigs This benefit is offered for hair loss as a result of chemotherapy. You can purchase wigs through a durable medical equipment (DME) supplier or supplier of your choice. Plan pays up to $400 every year. You are responsible for any costs over the benefit amount. To find a DME supplier you can call the phone number on your Member ID card or visit our online directory at aet.na/search. If you choose to use a supplier that is not in the DME network, you will need to pay out-of-pocket and submit a claim for reimbursement along with the receipt. You will only be reimbursed up to the benefit amount. You can find the reimbursement form at AetnaMedicare.com/forms.	$0 copay for a wig.	$0 copay for a wig.

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

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health family of companies. Other providers are available in our network.

Prescription Drug Schedule of Cost Sharing

Former Employer/Union/Trust Name: **Parkway School District**
Group Agreement Effective Date: **01/01/2025**
Master Plan ID: **0014142**

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
Annual Out-of-Pocket Limit:	$2,000
Retail Pharmacy Network:	S2
The name of your pharmacy network is listed above. To find a network pharmacy, or find up-to-date information about our network pharmacies, please call Member Services at the number on the back of your member ID card or consult the online *Pharmacy Directory* at AetnaRetireePlans.com.	

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.

Initial Coverage Stage: In this stage, you pay your share of covered Part D drug costs until you reach the $2,000 annual out-of-pocket limit.

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 $10	You pay $10	You pay $10	You pay $20	You pay $20
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 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

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

*Out-of-network coverage is limited to certain situations. 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.

Catastrophic Coverage Stage: You enter the Catastrophic Coverage Stage when you reach the $2,000 annual out-of-pocket limit and you will remain in this stage for the rest of the plan year.

During this payment stage, you pay nothing for your covered Part D drugs.

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 2025 Group Formulary (List of Covered Drugs)* for more information.

Form Approved
OMB#0938-1421

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 1-888-267-2637. Someone who speaks English 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 1-888-267-2637. 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 1-888-267-2637。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 1-888-267-2637。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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637 . 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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、1-888-267-2637. 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 1-888-267-2637. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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Form CMS-10802
(Expires 12/31/25)

Aetna Medicare Plan (PPO) Member Services

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

State Health Insurance Assistance Program (SHIP)

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Contact information for your state's SHIP is in **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.*