Aetna Medicare

Former Employer/Union/Trust Name: **FRESNO UNIFIED SCHOOL DISTRICT**
Group Agreement Effective Date: **01/01/2026**
Master Plan ID: **0015158**

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

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

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

If you receive services from:	If your plan services include:	You will pay:
A primary care provider (PCP): • 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.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay in-network and out-of-network
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered 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 8 sessions will be covered for 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 master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.	$0 copay for each Medicare-covered acupuncture visit.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Acupuncture for chronic low back pain *(continued)* 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.	
Acupuncture services (additional) In addition to the acupuncture services described above, we cover: • Acupuncture services in place of anesthesia for a surgical or dental procedure covered under the plan • Services for the relief of chronic pain • twenty visits every year To find a network provider, call the Member Services number on your member ID card or visit our online directory at **aet.na/search**. **Note:** (i) Services must be medically necessary. (ii) Services must be provided by appropriately licensed individuals practicing within the scope of their license.	$0 copay for each additional non-Medicare covered acupuncture service.
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. **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.**	$0 copay for each Medicare-covered one-way trip via ground or air ambulance.
Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the Welcome to	$0 copay for an annual routine physical exam.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Annual routine physical *(continued)* 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.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram each calendar year for women aged 40 and older • 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.**	There is no coinsurance, copayment, or deductible for covered screening mammograms. $0 copay for each diagnostic mammogram.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copay for each Medicare-covered cardiac rehabilitation service. $0 copay for each Medicare-covered intensive cardiac rehabilitation service.

Covered Service	What you pay in-network and out-of-network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • 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.**	$0 copay for each Medicare-covered chiropractic visit.
Chiropractic services (additional) In addition to the chiropractic service described above, we cover some additional specific services you receive from a licensed chiropractor. We cover twenty eight visits every year with a licensed chiropractor for additional services. To locate a network provider, you may contact Member Services at the phone number on your member ID card or visit our online directory at **aet.na/search**. **Note:** (i) Services must be medically necessary. (ii) Services must be provided by appropriately licensed individuals practicing within the scope of their license. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each additional non-Medicare covered chiropractic visit.

Covered Service	What you pay in-network and out-of-network
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. **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.**	Cost sharing for this service will vary depending on individual services provided under the course of treatment.
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 aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Twice per calendar year. • Screening Guaiac-based fecal occult blood test (gFOBT) for patients 45 years and older. Twice per calendar year. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. *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. Diagnostic colonoscopy: $0 copay **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.

Covered Service	What you pay in-network and out-of-network
Colorectal cancer screening *(continued)* • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Compression stockings Compression garments are usually made of elastic material, and are used to promote venous or lymphatic circulation. Compression garments worn on the legs can help prevent deep vein thrombosis and reduce edema, and are useful in a variety of peripheral vascular conditions. We cover unlimited singles/pairs every year.	$0 copay
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each Medicare-covered dental care service.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Diabetes screening *(continued)* You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
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 meter, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and meters. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • Continuous glucose monitors (CGMs) are considered durable medical equipment (DME) and are subject to applicable DME cost sharing. **Important Blood Glucose Monitoring Information:** • We exclusively cover Accu-Chek/Roche and TRUE/Trividia blood glucose meters and test strips as our preferred diabetic supplies. Non-Accu-Chek/Roche and non-TRUE/Trividia meters, 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. • You must obtain your Accu-Chek/Roche and TRUE/Trividia 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. • Accu-Chek/Roche and TRUE/Trividia 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	$0 copay for each Medicare-covered supply to monitor blood glucose from Accu-Chek/Roche and TRUE/Trividia, or from a non-preferred provider when a prior authorization is received. $0 copay for each pair of Medicare-covered diabetic shoes and inserts. $0 copay for Medicare-covered diabetes self-management training. We cover diabetic supplies made by Accu-Chek/Roche and TRUE/Trividia. We exclusively cover Accu-Chek/Roche and TRUE/Trividia glucose meters and test strips. We also cover Accu-Chek/Roche and TRUE/Trividia lancets, solutions, and lancing devices. We do not cover other brands of meters and test strips unless you or your provider requests a medical exception and it is approved. Non-Accu-Chek/Roche and non-TRUE/Trividia meters and test strips without a medical exception, or a medical exception that is not approved, will not be covered.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Diabetes self-management training, diabetic services and supplies *(continued)* formulary guide. **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 aren't limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. Your provider must provide a prescription for covered DME and obtain prior authorization if required. Our plan recommends preauthorization of the service when provided by an out-of-network provider. In Original Medicare, there is a rental policy up to the purchase price for certain types of DME after making copayments for the rental period. The rental period typically lasts between 10 to 13 months. Once the purchase price is met, you can use the equipment as long as it is needed. Once it is no longer needed, the issuing provider will need to pick it up. Under certain limited circumstances we will transfer ownership of the DME item to you. The most recent list of participating network pharmacies and suppliers is available on our website at **AetnaRetireePlans.com** Continuous glucose monitors (CGMs) and supplies are available through participating DME providers. Dexcom and FreeStyle Libre continuous glucose monitors and sensors are available without a prior authorization at network pharmacies with a history of insulin usage in the past 6 months. For those not using insulin as part of their treatment plan, prior authorization will be required for monitors and sensors. Prior authorization for monitors and sensors may apply as well as exception requests if exceeding quantity limits that align to Medicare coverage guidance. For a list of DME providers, visit **Aetna.com/dsepublicContent/assets/pdf/en/DME_National_Provider_Listing.pdf**.	$0 copay for each Medicare-covered durable medical equipment (DME) item.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Durable medical equipment (DME) and related supplies *(continued)* **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 - Foot orthotics Your plan covers foot orthotics. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for foot orthotics.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services 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.	$0 copay for emergency care. $0 copay for emergency care worldwide (i.e., outside the United States). $0 copay for each one-way trip via ground or air ambulance worldwide (i.e., outside the United States).
Fitness program (physical fitness) You are covered for a basic membership to any SilverSneakers® participating fitness facility.	$0 copay for basic health club membership/fitness classes at participating SilverSneakers locations.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Fitness program (physical fitness) *(continued)* If you do not reside near a participating facility, or prefer to exercise at home, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers. Included with your basic SilverSneakers membership, you will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. Health and wellness classes include, but are not limited to: cooking, food & nutrition, and mindfulness. Mental fitness classes include, but are not limited to: new skills, organization, self-help, and staying connected. These classes can be accessed online by visiting **SilverSneakers.com**. 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. Important: You get a basic membership at any participating SilverSneakers location. Facility amenities may vary by participating location including but not limited to hours, days and class types.	
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. * While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics. **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. $0 copay for Health education.

Covered Service	What you pay in-network and out-of-network
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. In addition to Medicare-covered benefits, we also offer: • Routine hearing exams: one exam every twelve months	$0 copay for each Medicare-covered hearing exam. $0 copay for each non-Medicare covered routine hearing exam.
Hearing services — Hearing aids This is a reimbursement benefit towards the cost of hearing aids. You may see any licensed hearing provider in the U.S. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment. If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing information, which will delay the processing time. **Notes:** • If you use a non-licensed provider, you will not receive reimbursement. • You are responsible for any charges above the reimbursement amount. ***** *Amounts you pay for hearing aids do not apply to your Out-of-Pocket Maximum.*	Our plan will reimburse you up to $1,000 once every 36 months towards the cost of hearing aids.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to:	$0 copay for each Medicare-covered home health service. $0 copay for each Medicare-covered durable medical equipment (DME) item.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Home health agency care *(continued)* • 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.**	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Prior to receiving home infusion services, they must be ordered by a doctor and included in your care plan. Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You will pay the cost sharing that applies to primary care provider services, specialist physician services (including certified home infusion providers), or home health services depending on where you received administration or monitoring services. (See **Physician/Practitioner services, including doctor's office visits** or **Home health agency care** for any applicable cost sharing.) **Note:** Home infusion drugs, pumps, and devices provided during a home infusion therapy visit are covered separately under your **Durable medical equipment (DME) and related supplies** benefit.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. *This service is continued on the next page*	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

Covered Service	What you pay in-network and out-of-network
Hospice care *(continued)* Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B and aren't related to your terminal prognosis, you pay your plan cost-sharing amount for these services and you must follow plan rules (like there's a requirement to get prior authorization). **For services covered by Aetna Medicare Plan (PPO) but not covered by Medicare Part A or B:** Aetna Medicare Plan (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4 of your *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.	apply for outpatient consultations.

Covered Service	What you pay in-network and out-of-network
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 of the *Evidence of Coverage* for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. $0 copay for all other vaccines covered under Medicare Part B. 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're formally admitted to the hospital with a doctor's order. The day before you're 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 aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you	For each inpatient hospital stay, you pay: $0 per stay. Cost sharing is charged for each medically necessary covered inpatient stay.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Inpatient hospital care *(continued)* need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All components of blood are covered starting with the first pint. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at **www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Days covered: There is no limit to the number of days covered by our plan. Cost sharing is not charged on the day of discharge. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	For each inpatient stay, you pay: $0 per stay. Cost sharing is charged for each medically necessary covered inpatient stay.

Covered Service	What you pay in-network and out-of-network
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your skilled nursing facility benefits or if the skilled nursing facility or inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for Medicare-covered primary care provider (PCP) services. $0 copay for Medicare-covered specialist services. $0 copay for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered lab service. $0 copay for each Medicare-covered diagnostic radiology and complex imaging service. $0 copay for each Medicare-covered x-ray. $0 copay 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 monitor supplies. $0 copay for each Medicare-covered prosthetic and orthotic device. $0 copay for each Medicare-covered physical or speech therapy visit. $0 copay for each Medicare-covered occupational therapy visit.
Meal benefit After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility stay, you may be eligible to get up to 14 freshly prepared meals for a 7-day period. These meals are provided to help support your recovery or manage your health conditions. We have teamed up with NationsMarket™ to provide this benefit. After we confirm your eligibility, NationsMarket will contact you to coordinate the delivery. **Note:** Observation and outpatient stays do not qualify you for this benefit. Meals must be scheduled for delivery within three months of the qualifying discharge as long as you are enrolled in the plan.	$0 copay for meals.

Covered Service	What you pay in-network and out-of-network
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 the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B 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 get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could 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. Medicare Part D drug coverage covers immunosuppressive drugs if Part B	$0 copay per prescription or refill. $0 copay for each chemotherapy or infusion therapy Part B drug. $0 copay for the administration of the chemotherapy drug as well as for infusion therapy. $0 copay for each allergy shot. You may have to pay an office visit cost share if you get other services at the same time that you get the allergy shot. $0 copay for each insulin Part B drug. Part B drugs may be subject to Step Therapy requirements.
This service is continued on the next page	

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

Covered Service	What you pay in-network and out-of-network
Medicare Part B drugs (continued) benefit. Chapter 5 of the *Evidence of Coverage* explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D drugs through our plan is explained in Chapter 6 of the *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.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each Medicare-covered opioid use disorder treatment service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings	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
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Outpatient diagnostic tests and therapeutic services and supplies *(continued)* • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All components of blood are covered starting with the first pint. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each Medicare-covered x-ray. $0 copay for each Medicare-covered lab service. $0 copay for Medicare-covered blood services. $0 copay for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered diagnostic radiology and complex imaging service. $0 copay for each Medicare-covered CT scan. $0 copay for each Medicare-covered diagnostic radiology service other than CT scan. $0 copay 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 monitor supplies.
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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered	Your cost share for Observation Care is based upon the services you receive.

This service is continued on the next page

Covered Service	What you pay in-network and out-of-network
Outpatient hospital observation *(continued)* an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (**1-800-633-4227**). TTY users call **1-877-486-2048**.	
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 aren't 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 you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay 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 $0 copay for emergency care. $0 copay for each Medicare-covered diagnostic procedure and test. $0 copay for each Medicare-covered lab service. $0 copay for each Medicare-covered diagnostic radiology and complex imaging service. $0 copay for each Medicare-covered x-ray. $0 copay for each Medicare-covered therapeutic radiology service. $0 copay for each Medicare-covered individual session for outpatient psychiatrist service. $0 copay for each Medicare-covered group session for outpatient psychiatrist service. $0 copay for each Medicare-covered individual session for outpatient mental health service.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Outpatient hospital services *(continued)*	$0 copay for each Medicare-covered group session for outpatient mental health service. $0 copay for each Medicare-covered partial hospitalization visit. $0 copay for each Medicare-covered intensive outpatient visit. Your cost share for medical supplies is based upon the provider of services. $0 copay for continuous glucose monitor supplies. $0 copay 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), 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.**	$0 copay for each Medicare-covered individual session for outpatient psychiatrist service. $0 copay for each Medicare-covered group session for outpatient psychiatrist service. $0 copay for each Medicare-covered individual session for outpatient mental health service. $0 copay for each Medicare-covered group session for outpatient mental health service.
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).	$0 copay for each Medicare-covered physical or speech therapy visit. $0 copay 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	$0 copay for each Medicare-covered individual session for outpatient substance use disorder service.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Outpatient substance use disorder services *(continued)* been discharged from an inpatient stay for the treatment of substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare-eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief interventions or advice focusing on increasing insight and awareness regarding substance use and motivation toward behavioral change **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each Medicare-covered group session for outpatient substance use disorder service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. **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 $0 copay for each Medicare-covered outpatient surgery at a hospital outpatient facility. $0 copay 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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a	$0 copay for each Medicare-covered partial hospitalization visit. $0 copay for each Medicare-covered intensive outpatient visit.

This service is continued on the next page

Covered Service	What you pay in-network and out-of-network
Partial hospitalization services and Intensive outpatient services *(continued)* hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. **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 you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: ◦ Primary care provider services ◦ Physician specialist services ◦ Mental health services (individual sessions) ◦ Mental health services (group sessions) ◦ Psychiatric services (individual sessions) ◦ Psychiatric services (group sessions) ◦ Urgently needed services ◦ Occupational therapy services ◦ Physical and speech therapy services ◦ Opioid treatment services ◦ 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**.	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 $0 copay for Medicare-covered primary care provider (PCP) services (including urgently needed services). $0 copay for Medicare-covered physician specialist services (including surgery second opinion, home infusion professional services, and urgently needed services). Your cost share for cancer-related treatment is based upon the services you receive. $0 copay for each Medicare-covered hearing exam. Certain additional telehealth services, including: • $0 copay for each primary care provider service • $0 copay for each physician specialist service
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network

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

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Covered Service	What you pay in-network and out-of-network
Physician/Practitioner services, including doctor's office visits *(continued)* • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • 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	$0 copay for each Medicare-covered podiatry visit.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: *This service is continued on the next page*	There is no coinsurance, copayment, or deductible for each Medicare-covered PrEP service.

Covered Service	What you pay in-network and out-of-network
Pre-exposure prophylaxis (PrEP) for HIV prevention *(continued)* • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	$0 copay for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision care* later in this table. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 copay for each Medicare-covered prosthetic and orthotic device. Your cost share for medical supplies is based upon the provider of services.
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.	$0 copay 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	There is no coinsurance, copayment, or deductible for Resources For Living.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Resources For Living® *(continued)* information for a wide variety of eldercare and life-related issues. Call Resources For Living to find services in your area at 1-866-370-4842 (**TTY:** 711), Monday–Friday, 8 AM to 8 PM ET. A resource consultant will answer your call.	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for each Medicare-covered screening for the Hepatitis C Virus.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Screening for lung cancer with low dose computed tomography (LDCT) *(continued)* counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease 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 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior**	$0 copay for self-dialysis training. $0 copay for each Medicare-covered kidney disease education session. $0 copay for in- and out-of-area outpatient dialysis. For each inpatient hospital stay, you pay: $0 per stay. Cost sharing is charged for each medically necessary covered inpatient stay. $0 copay for home dialysis equipment and supplies. $0 copay for Medicare-covered home support services.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Services to treat kidney disease *(continued)* **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, go to Chapter 12 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 aren't 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 our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All components of blood are covered starting with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	$0 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.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling	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.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) *(continued)* • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) 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	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay for each Medicare-covered Supervised Exercise Therapy service.
Transportation services (non-emergency) We cover: • 24 one-way trips to and from plan-approved locations each year	$0 copay per trip.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Transportation services (non-emergency) *(continued)* Trips must be within 60 miles of provider location. Coverage includes trips to and from providers or facilities for services that your plan covers. The transportation service will accommodate urgent requests for hospital discharge, dialysis, and trips that your medical provider considers urgent. The service will try to accommodate specific physical limitations or requirements. However, it limits services to wheelchair, taxi, or sedan transportation vehicles. • Transportation services are administered through MTM Health • To arrange for transport, call **1-855-814-1699 (TTY: 711)**, Monday through Friday, 7 AM to 8 PM local time • You must schedule transportation service at least two business days before the appointment • You must cancel up to one business day in advance, or MTM Health will deduct the trip from the remaining number of trips available • This program doesn't support stretcher vans/ambulances	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. In addition to Medicare-covered benefits, we also offer: • Urgent care (worldwide) You may have to pay the provider at the time of service and submit for reimbursement.	$0 copay for each Medicare-covered urgent care facility visit. (See **Physician/Practitioner services, including doctor's office visits** for information about urgently needed services provided in a physician's office.) $0 copay for each urgent care facility visit worldwide (i.e., outside the United States).
Vision care Covered services include: *This service is continued on the next page*	$0 copay for each Medicare-covered eye exam. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for

Covered Service	What you pay in-network and out-of-network
Vision care *(continued)* • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening every 12 months. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. In addition to Medicare-covered benefits, we also offer: • Non-Medicare covered eye exams: one exam every year • Follow-up diabetic eye exam	those additional services received. $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. $0 copay for each non-Medicare covered routine eye exam. If you receive additional services during the eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, you may also be responsible for a cost share for those additional services received.
Vision care — eyewear reimbursement (non-Medicare covered) Non-Medicare covered prescription eyewear includes: • 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:**	Our plan will reimburse you up to: $100 once every 12 months towards the cost of eyewear. You may be required to pay for services up front and submit for reimbursement.
This service is continued on the next page	

Covered Service	What you pay in-network and out-of-network
Vision care — eyewear reimbursement (non-Medicare covered) *(continued)* • 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 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 want 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.
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.

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

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

Prescription Drug Schedule of Cost Sharing

Former Employer/Union/Trust Name: **FRESNO UNIFIED SCHOOL DISTRICT**
Group Agreement Effective Date: **01/01/2026**
Master Plan ID: **0015158**

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

Annual Deductible Amount:	$0
Formulary Type:	Comprehensive Plus
Number of Cost-Share Tiers:	5 Tier
Annual Out-of-Pocket Limit:	$2,100
Maximum Out-of-Pocket Amount	$400
Once your individual out-of-pocket expenses reach this amount, you will pay $0 for all covered prescription drugs for the remainder of the plan year including those drugs covered on the non-Part D supplemental benefit.	
Retail Pharmacy Network:	P1
The name of your pharmacy network is listed above. The Aetna Medicare pharmacy network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost-sharing may be less at pharmacies with preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call **1-855-338-7027** (**TTY: 711**) or consult the online pharmacy directory at **AetnaRetireePlans.com**.	

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

- Tier One – Preferred generic drugs
- Tier Two – Generic drugs
- Tier Three – Preferred brand drugs
- Tier Four – Non-preferred brand drugs
- Tier Five – 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 our plan's Drug List. If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

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

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

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

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 1 Preferred Generic drugs	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Tier 2 Generic drugs	You pay $10	You pay $10	You pay $10	You pay $20	You pay $18
Tier 3 Preferred Brand drugs	You pay $35	You pay $35	You pay $35	You pay $70	You pay $70
Tier 4 Non-Preferred Brand drugs	You pay $50	You pay $50	You pay $50	You pay $100	You pay $100
Tier 5 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay $50	You pay $50	You pay $50	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. Go to the *Evidence of Coverage* Chapter 5, Section 2.4 (*Using a pharmacy that's not in our plan's network)* for more information.

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

Initial Coverage	One-Month Supply			Extended Supply	
	Preferred retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Preferred retail cost sharing** (up to a 90-day supply)	**Preferred mail order cost sharing** (up to a 90-day supply)
Tier 1 Preferred Generic drugs	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
Tier 2 Generic drugs	You pay $9	You pay $10	You pay $10	You pay $18	You pay $18
Tier 3 Preferred Brand drugs	You pay $35	You pay $35	You pay $35	You pay $70	You pay $70
Tier 4 Non-Preferred Brand drugs	You pay $50	You pay $50	You pay $50	You pay $100	You pay $100
Tier 5 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay $50	You pay $50	You pay $50	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. Go to the *Evidence of Coverage* Chapter 5, Section 2.4 (*Using a pharmacy that's not in our plan's network)* for more information.

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

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

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

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

Non-Part D Supplemental Benefit

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

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

The cost share for these drugs throughout all drug payment stages is listed in the Initial Coverage Stage table above. See Tier 1 for the generic cost share amount and Tier 3 for the brand cost share amount.

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

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

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

Notice of Availability (NOA)

TTY: 711

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

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

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

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。 (Chinese)

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

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

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

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

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

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

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

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

လၢကမၤနၢ် ကျၢ်ဘၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢ်ဘူၣ်လၢ်စၢ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ လၢအအိၣ် ဖဲန ID အဖီခိၣ်နၣ် တကၢ်. (Karen)

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

ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບ ເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ຍໃນ ບັດປະຈຳຕົວຂອງທ. (Laotian)

ដើម្បីទទួល នេស ផែ ក េយមិនគិតៃថ ពីអ កសូមទូរសព េលេខែដល នេ លើ តស ល់ខ នរបស់អ ក។ (Mon-Khmer, Cambodian)

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

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

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

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

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

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

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

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Aetna Medicare Plan (PPO) Member Services

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

State Health Insurance Assistance Program (SHIP)

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

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, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*