Benefits and Premiums are effective January 1, 2025 through December 31, 2025

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.	
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No	
Annual Deductible	$0	$0
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.		
Annual Maximum Out-of-Pocket Amount	**Network Services:**	**Network and out-of-network services:**
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$2,750	$5,450 for in and out-of-network services combined
It will apply to all medical expenses except Hearing Aid Reimbursement that may be available on your plan.		

HOSPITAL CARE*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Inpatient Hospital Care	$500 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Observation Stay	Your cost share for Observation Care is based upon the services you receive	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay	per stay
Outpatient Services & Surgery	15%	25%
Ambulatory Surgery Center	15%	25%
PHYSICIAN SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Primary Care Physician Visits	15%	25%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	15%	25%
PREVENTIVE CARE	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Medicare-covered Preventive Services	$0	25%

• Abdominal aortic aneurysm screenings

• Alcohol misuse screenings and counseling

• Annual Well Visit - One exam every 12 months.

• Bone mass measurements

• Breast exams

• Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.

• Cardiovascular behavior therapy

• Cardiovascular disease screenings

• Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.

- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit

Medicare-covered Preventive Services (continued)		
• Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.	$0	$0
Immunizations • Flu • Hepatitis B • Pneumococcal	$0	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0	25%

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	$50	$50
Urgently Needed Care; Worldwide	$35	$35
DIAGNOSTIC PROCEDURES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Diagnostic Radiology CT scans	15%	25%
Diagnostic Radiology Other than CT scans	15%	25%
Lab Services	15%	25%
Diagnostic testing & procedures	15%	25%
Outpatient X-rays	15%	25%
HEARING SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Routine Hearing Screening We cover one exam every twelve months	$0	25%
Medicare Covered Hearing Examination	15%	25%
Hearing Aid Reimbursement	$1,000 once every 36 months	
DENTAL SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Medicare Covered Dental* Non-routine care covered by Medicare.	15%	25%

VISION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	$0	25%
Diabetic Eye Exams	$0	25%
Medicare Covered Eye Exam	15%	25%
MENTAL HEALTH SERVICES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Inpatient Mental Health Care	$500 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care Individual visit	15%	25%
Partial Hospitalization and Intensive Outpatient Services	15%	25%
Inpatient Substance Abuse	$500 per stay	25% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse Individual visit	15%	25%
SKILLED NURSING SERVICES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Skilled Nursing Facility (SNF) Care	0% per day, days 1-20; 15% per day, days 21-100	25% per day, days 1-100

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient 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. 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.

PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	15%	25%

AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Ambulance Services	15%	25%

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.

TRANSPORTATION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Transportation (non-emergency)	24 one-way trips with 60 miles allowed per trip	

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Part B Prescription Drugs	$0	25%
Medicare Part B Prescription Drugs - Insulin	$0	$0

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Allergy Shots	$0	25%
Allergy Testing	15%	25%
Blood All components of blood are covered beginning with the first pint.	$0	25%
Cardiac Rehabilitation Services	15%	25%
Intensive Cardiac Rehabilitation Services	15%	25%
Chiropractic Services* Medicare covered benefits only.	15%	25%
Diabetic Supplies* Includes supplies to monitor your blood glucose from LifeScan.	$0	25%
Durable Medical Equipment/ Prosthetic Devices*	15%	25%
Home Health Agency Care*	$0	25%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	15%	25%
Outpatient Dialysis Treatments*	15%	15%
Podiatry Services Medicare covered benefits only.	15%	25%
Pulmonary Rehabilitation Services	15%	25%
Supervised Exercise Therapy (SET) for PAD Services	15%	25%
Radiation Therapy*	15%	25%
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Fitness Benefit	SilverSneakers®	

Healthy Rewards	Covered	
Meals	$0	
Covered up to 14 meals following an inpatient stay.		
Resources For Living®	Covered	
For help locating resources for every day needs.		
Smoking and Tobacco Use Cessation Supplies	$0	25%
Frequency	unlimited visits every year	unlimited visits every year
Teladoc™	$0	
Telemedicine services with a Teladoc™ provider. State mandates may apply.		
Telehealth	Covered	
Telemedicine Services. Member cost share will apply based on services rendered.		
Telehealth PCP	15%	25%
Telehealth Specialist	15%	25%
Telehealth Occupational Therapy Services	15%	25%
Telehealth PT and SP Services	15%	25%
Telehealth Other Health care Providers	15%	25%
Telehealth Individual Mental Health	15%	25%
Telehealth Group Mental Health	15%	25%
Telehealth Individual Psychiatric Services	15%	25%
Telehealth Group Psychiatric Services	15%	25%
Telehealth Individual Substance Abuse Services	15%	25%
Telehealth Group Substance Abuse Services	15%	25%
Telehealth Kidney Disease Education Services	$0	25%
Telehealth Diabetes Self-Management Training	$0	25%
Telehealth Opioid Treatment Program Services	15%	25%
Telehealth Urgent care	$35	$35
Wigs*	$0	$0
Maximum	$400	

Frequency	every year	
ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Compression Stockings	$0	$0
Maximum	unlimited singles/pairs	unlimited singles/pairs
Frequency	every year	every year
Routine Physical Exams	$0	25%
One exam per calendar year		

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Medical Disclaimers

For more information about Aetna plans, go to **www.AetnaRetireePlans.com** or call Member Services toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Not all PPO Plans are available in all areas

The provider network may change at any time. You will receive notice when necessary.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

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

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Plan Disclaimers

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

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna).

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

To join the Aetna Medicare Advantage Plan Open Access PPO , you must meet the requirements of the plan sponsor/your former employer, be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

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

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

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

You can read the *Medicare & You 2025* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at http://www.aetnaretireeplans.com. As a reminder, our website has

the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830번으로 문의해 주십시오.

한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

:Arabic
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-307-4830. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-307-4830にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-800-307-4830. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

*****This is the end of this plan benefit summary*****

Y0001_GRP_1099_3731a_2021_M