aetna®

# We've got a plan that can make an important difference in your life

You worked hard all your life. That's why the Labor Benefits Association (LBA) and Aetna teamed up to offer you a Medicare Advantage plan—also called the Aetna Medicare℠ Plan (PPO) with Extended Service Area.

It's more than just a plan that helps pay your medical and prescription drug costs. It's a plan to help you live the kind of life you want in your retirement years.

This packet will help you understand the value of this plan option, how to learn more and how to enroll. Be sure to review the following enclosed documents:

- Summary of benefits
- Enrollment form
- Pension authorization form
- For your doctor flyer
- SilverSneakers

## Ready to enroll?

Complete the enclosed enrollment form and pension deduction authorization form, and mail back using the postage-paid envelope.

### To get more information or join the LBA*:

Call Doyle Rowe LTD at **1-866-201-2524**, Monday–Friday, 8:30 AM–4:30 PM CT.

*Instructions on joining the LBA can be provided by Doyle Rowe. There is a $36 annual membership fee.

### For questions about the plan:

Call Aetna at **1-800-307-4830 (TTY: 711)**, Monday–Friday, 7 AM–8 PM CT

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


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832849-01-01 (10/23)

# Participant Authorization for the Deduction of Healthcare Premiums

## IMPORTANT LEGAL NOTICE

The Municipal Employees' Annuity and Benefit Fund of Chicago (the "Fund") is proceeding with allowing for a monthly healthcare insurance premium deduction (the "Deduction") from an annuitant's net monthly annuity benefit (the "Annuity") to the healthcare insurance plan provider ("Provider") stated below. The Deduction is pursuant to the statutory authority under Section 8-244(b) (1) of the Illinois Pension Code, with the understanding that this action might require revisions and adjustments. The Fund takes no position with respect to annuitant health care options and does not endorse or sponsor any particular healthcare insurance carrier or healthcare insurance coverage. In processing the Deduction, the Fund is solely performing an administrative function and is only responsible for the Deduction of premiums requested by your Provider. Any dispute regarding the Deduction amount is solely between the annuitant and the Provider.

A completed and signed form does not guarantee that the Fund will process the Deduction from the Annuity. The Provider must comply with all Fund requirements to process any Deduction from an Annuity. The annuitant is responsible for making premium payments to their Provider until the Fund receives and processes the completed and signed form. The Fund will continue to make the Deduction until written notification of cancellation is received. If an annuitant's Deduction exceeds his/her Annuity, the Fund cannot make any Deduction on their behalf.

## WAIVER OF CLAIMS AND AUTHORIZATION

Pursuant to Section 8-244(b) (1) of the Illinois Pension Code, I hereby authorize and direct the Fund to make a Deduction for my monthly healthcare premium. I understand that the Deduction will be taken from my net monthly annuity benefit.

Member Name (First, Middle Initial and Last): _____

Last 4 digits of Social Security Number: _____

Persons Insured (if other than Member): _____ Last 4 digits SS#: _____
Persons Insured (if other than Member): _____ Last 4 digits SS#: _____
Persons Insured (if other than Member): _____ Last 4 digits SS#: _____
Persons Insured (if other than Member): _____ Last 4 digits SS#: _____

Phone Number: _____

**Provider Information:**

Provider Name: **AETNA** Plan Name: _____

As a condition of authorizing this Deduction, I accept all responsibility for truth and accuracy of all information I have provided. I hereby release the Fund, its staff, its officers, its Board of Trustees, and any of its advisors from any liability arising from the administration of the Deduction out of my Annuity. By signing this form, I agree that I will not make any legal claim of any kind against the Fund, its staff, officers, its Board of Trustees, and any of its advisors. Should my authorization result in any liability to me, including interest, penalties or tax, I understand that my ability to participate in this program is a valuable benefit for which I am willing to sign this Waiver of All Claims.

I have read and understand the information contained on this form and its instructions and agree to all the conditions for this authorization, including the Waiver of All Claims against the Fund, its staff, its officers, its Board of Trustees, and any of its advisors.

**Annuitant Signature** _____ **Date** _____

**Spouse Signature (If Applicable)** _____

**** THIS LINE MUST BE FULLY EXECUTED AND SIGNED ****

## ENROLLMENT CHECKLIST

**Please make sure that all of the following are in the provided postage paid envelope before mailing:**

☐ Completed application(s) with signature and plan choice – your spouse must complete their own separate application.

☐ Completed and signed pension deduction authorization.

☐ Annual membership fee check or money order made payable to Labor Benefits Association (LBA) in the amount of $36.00 per household.

## LABOR BENEFITS ASSOCIATION (LBA)

### LABOR BENEFITS ASSOCIATION (LBA) MEMBERSHIP INFORMATION

The LBA was formed to develop plans that are more affordable, provide a robust benefit package and protect from significant rate increases. The LBA is a non-profit organization whose sole purpose will be to provide benefits to participating members.

In order to participate in the LBA sponsored AETNA MAPD plan(s) you must be an LBA member. LBA membership fees are $36.00 per household per year. Please enclose a check or money order made payable to Labor Benefits Association in the amount of $36.00 along with your application.

## PERSONAL INFORMATION

LAST NAME FIRST NAME MI MR., MRS., MS.

DATE OF BIRTH GENDER

PERMANENT RESIDENCE (CAN NOT BE A P.O. BOX)

CITY STATE ZIP COUNTY

PHONE CELL EMAIL (OPTIONAL)

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT ADDRESS)

CITY STATE ZIP COUNTY

EMERGENCY CONTACT NAME (OPTIONAL) RELATIONSHIP TO YOU

EMERGENCY CONTACT PHONE NUMBER EMERGENCY CONTACT CELL NUMBER

I am the Annuitant Payee ☐ Yes ☐ No

If No, Name of Annuitant Payee_____ Annuitant Payee SSN_____

Annuitant Payee receives his/her pension from: CHECK ONE

☐ Municipal Employees Annuity and Benefit Fund (MEABF) ☐ Laborers' Annuity and Benefit Fund (LABF)

**Please complete and return the applicable pension deduction authorization along with this application in the postage paid envelope included with this packet.**

## MEDICARE INFORMATION

Please take out your red, white and blue Medicare card to complete this section or attach a copy of your Medicare card or your letter from social security or the railroad retirement board.

NAME (AS IS APPEARS ON YOUR MEDICARE CARD)

MEDICARE NUMBER

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A)

MEDICAL (PART B)

**YOU MUST BE ENROLLED IN MEDICARE PART B AND CONTINUE TO PAY THE PART B PREMIUM TO BE ELIGIBLE FOR THE FOLLOWING AETNA PLANS.**

**Health Plan Selection:**

Check the box next to the plan in which you wish to enroll:

☐ AETNA MAPD PPO PART B PREMIER $708.28 per member per month

☐ AETNA MAPD PPO PART B STANDARD $594.90 per member per month

Please complete the following:

☐ I'd like to change to an AETNA plan. I understand this plan may have different health benefits and monthly payments than my current plan. I am currently enrolled in a Medicare Advantage plan issued by _____

Insurance Company Name

## MEDICARE – RELATED QUESTIONS

☐ Yes ☐ No Do you have end-stage renal disease (ESRD)? If you've had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you've had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.
If yes, what is the date of your first dialysis treatment? Month:_____ Year_____

☐ Yes ☐ No Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible? If so, Medicare Advantage coverage will be your secondary coverage for the first 30 months of the coordination period.
If yes, provide your prior commercial coverage carrier's name:_____

☐ Yes ☐ No Are you a resident of a long-term care facility, such as a nursing home?
If yes, provide the following information:

NAME OF INSTITUTION PHONE

CITY STATE ZIP COUNTY

☐ Yes ☐ No Are you enrolled in your state Medicaid program? If yes, provide

MEDICAID NUMBER

Indicate your preferred language (if not English) _____

**Please contact 1-800-307-4830 (TTY: 711), Monday – Friday, 7 a.m. to 8 p.m. CST. If you need information in another language or accessible format (e.g. large print or braille)**

## OTHER RX COVERAGE

### Complete only if you have other prescription drug coverage

Some individuals may have other drug coverage, including other private insurance, workers' compensation, VA benefits or through state pharmaceutical assistance programs.

☐ Yes ☐ No Will you have other prescription drug coverage in addition to the AETNA Medicare Advantage Rx plan? If yes, please list your other coverage and identification number(s) for this coverage:

_____

NAME OF OTHER COVERAGE

_____

ID NO. GROUP NO.

☐ Yes ☐ No Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?
If so, from (mm/dd/yy)_____to (mm/dd/yy)_____

Creditable coverage is coverage that is at least as good as Medicare prescription drug coverage.

**Note: If you have not had creditable coverage, you may have to pay a late enrollment penalty. AETNA may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call AETNA at 1-800-307-4830.**

## DISCLOSURES

By completing this enrollment application I agree to the following: AETNA Medicare is a PPO plan with a Medicare contract. Enrollment in the AETNA PPO plan depends on contract renewal. I will need to keep my Medicare Part B coverage. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances. Once I am a member of the AETNA Medicare advantage plan I have the right to appeal plan decisions about payment or services if I disagree. I will read the evidence of coverage document from AETNA when I get it to know which rules I must follow to get coverage under this Medicare advantage plan. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements.

I've been advised not to cancel, or drop any other Medicare advantage or supplemental insurance I currently have until I receive written notification of my confirmed effective date from AETNA. I understand the providers in the AETNA network are independent contractors in private practice and are neither employees nor agents of AETNA or its affiliates. I understand that beginning on the date AETNA Medicare Advantage plan coverage begins using services in network can cost less than using services out of network, except for emergency or urgently needed services or out of area dialysis services. I understand I can go to doctors, specialist or hospitals in or out of network. I understand that providers must be licensed and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the AETNA Medicare Advantage plan and other services contained in my AETNA Medicare Advantage evidence of coverage document (also known as the member contract or subscriber agreement will be covered. Without authorization when required by the plan, neither Medicare nor the AETNA Medicare advantage plan will pay for services.

## RELEASE OF INFORMATION

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request from Medicare.

SIGNATURE TODAY'S DATE

If you are an authorized representative, you must sign above and provide the following information:

REPRESENTATIVE'S NAME

ADDRESS

CITY STATE ZIP

PHONE NUMBER RELATIONSHIP TO ENROLLEE

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.

**Make a copy for yourself and return the original.**

### OFFICE USE ONLY

EFFECTIVE DATE

GROUP NUMBER/CLASS CODE

ELECTION TYPE

MAPD

# Labor Benefits Association

Sponsored by Aetna Medicare Plan (PPO)

(C04) ESA PPO Part B Only, Rx $6/20%/20%/20%Non

## Keep in mind

This is just a summary. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). You can request a copy of the SOC/EOC by contacting:

**Member Services**

**1-888-267-2637** (TTY: 711)

Hours are 8 AM to 9 PM ET, Monday through Friday.

## Are you eligible to enroll?

**To join Aetna Medicare Plan (PPO), you must:**

- Be enrolled in Medicare Part B
- Live in the plan's service area

This is a summary of the services we cover from January 1, 2024 through December 31, 2024.

Service area: A complete list of service areas can be found in the *Evidence of Coverage* (EOC).

## What You Should Know

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

| Plan costs & information | Network & Out-of-network providers |
|---|---|
| Premium | Please contact your former employer/union/trust for more information on your plan premium. |
| Annual Deductible | $0<br>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 | $0<br>The maximum out-of-pocket (MOOP) is the **most you'll pay** for the medical services we cover each year. **It's in place to protect you**. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP. |

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Hospital Care*** | |
| Inpatient Hospital Care | $0 per stay<br>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. |
| Frequency: | per stay |
| Outpatient Hospital Services and Surgery | $0 |
| Ambulatory Surgery Center | $0 |
| **Physician Services** | |
| Primary Care Physician Visits | $0<br>Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery. |
| Physician Specialist Visits | $0 |
| **Preventive Services** | |
| Abdominal aortic aneurysm screenings | $0 |
| Alcohol misuse screenings and counseling | $0 |
| Annual well visit - one exam every 12 months | $0 |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Preventive Services** (continued) | |
| Bone mass measurements | $0 |
| Breast exams | $0 |
| Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; one annual mammogram for members age 40 and over | $0 |
| Cardiovascular behavior therapy | $0 |
| Cardiovascular disease screenings | $0 |
| Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | $0 |
| Depression screenings | $0 |
| Diabetes screenings | $0 |
| HBV infection screening | $0 |
| Hepatitis C screening tests | $0 |
| HIV screenings | $0 |
| Lung cancer screenings and counseling | $0 |
| Medicare Diabetes Prevention Program (MDPP) | $0 |
| Nutrition therapy services | $0 |
| Obesity behavior therapy | $0 |
| Pelvic exams - one routine GYN visit and Pap smear every 24 months | $0 |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Preventive Services** (continued) | |
| 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 | $0 |
| Prostate cancer screenings (PSA) - for all male patients aged 50 or older (coverage begins the day after 50th birthday) | $0 |
| Sexually transmitted infections screening and counseling | $0 |
| Tobacco use cessation counseling | $0 |
| "Welcome to Medicare" preventive visit | $0 |
| **Immunizations** | |
| Flu | $0 |
| Hepatitis B | $0 |
| Pneumococcal | $0 |
| **Additional Medicare Preventive Services** | |
| Barium enema - one exam every 12 months | $0 |
| Diabetes self-management training (DSMT) | $0 |
| Digital rectal exam (DRE) | $0 |
| *This continues on the next page* | |

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Additional Medicare Preventive Services** (continued) | |
| EKG following welcome exam | $0 |
| Glaucoma screening | $0 |
| **Emergency and Urgent Medical Care** | |
| Emergency Care (includes services worldwide) | $0 |
| Urgent Care (includes services worldwide) | $0 |
| **Diagnostic Procedures*** | |
| Diagnostic Radiology (CT scans) | $0 |
| Diagnostic Radiology (other than CT scans) | $0 |
| Diagnostic Testing and Procedures | $0 |
| Lab Services | $0 |
| Outpatient X-rays | $0 |
| **Hearing Services** | |
| Hearing Exam (routine) | $0<br>Coverage: one exam every twelve months |
| Hearing Exam (Medicare-covered) | $0 |
| **Dental Services*** | |
| Dental Services | $0<br>Medicare-covered benefits only |
| **Vision Services** | |
| Eye Exam (routine) | $0 |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Vision Services** (continued) | |
| | Coverage: one exam every twelve months |
| Diabetic Eye Exam | $0 |
| Eye Exam (Medicare-covered) | $0 |
| **Mental Health Services*** | |
| Inpatient Mental Health Care | $0 per stay |
| | The member cost sharing applies to covered benefits incurred during a member's inpatient stay. |
| Outpatient Mental Health Care | $0 (individual sessions) |
| | $0 (group sessions) |
| Partial Hospitalization | $0 |
| Inpatient Substance Abuse | $0 per stay |
| | The member cost sharing applies to covered benefits incurred during a member's inpatient stay. |
| Outpatient Substance Abuse | $0 (individual sessions) |
| | $0 (group sessions) |
| **Skilled Nursing Services*** | |
| Skilled Nursing Facility (SNF) Care | $0 per day, days 1-100 |
| | Limited to 100 days per Medicare benefit period.<br>The member cost sharing applies to covered benefits incurred during a member's inpatient stay.<br>A benefit period begins the day you go into a hospital or skilled nursing |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Skilled Nursing Services*** (continued) | |
| | 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. |
| **Outpatient Rehabilitation Services** | |
| Occupational Therapy Rehabilitation Services | $0 |
| Physical and Speech Therapy Rehabilitation Services | $0 |
| **Ambulance* and Transportation Services** | |
| Ambulance Services | $0<br>Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Ambulance* and Transportation Services** (continued) | |
| | out-of-network provider. |
| Transportation (non-emergency) | Not Covered |
| **Medicare Part B Prescription Drugs*** | |
| Medicare Part B Prescription Drugs | $0 |
| ***These benefits may require prior authorization.** | |

## Medicare Part D Prescription Drugs

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section on page 14 for your plan benefits at each Part D phase, including cost share and other important pharmacy benefit information.

| ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)** | |
| Acupuncture Services | $0 |
| | Medicare-covered benefits only |
| Allergy Shots | $0 |
| Allergy Testing | $0 |
| Blood | $0 |
| | All components of blood are covered beginning with the first pint. |
| Cardiac Rehabilitation Services | $0 |
| Chiropractic Services* | $0 |
| | Medicare-covered benefits only |
| Diabetic Supplies* | $0 |
| | Includes supplies to monitor your blood glucose from LifeScan, or from a non-preferred provider when a prior authorization is received. |
| Durable Medical Equipment (DME)* | $0 |
| Home Health Agency Care* | $0 |
| Hospice Care | Your hospice services at a Medicare-certified hospice facility are paid for by Aetna at 100%. |
| Intensive Cardiac Rehabilitation Services | $0 |
| Medical Supplies* | Your cost share is based upon the provider of |

*This continues on the next page*

| ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)**(Continued) | |
| | services |
| Outpatient Dialysis Treatments* | $0 |
| Podiatry Services | $0 |
| | Medicare-covered benefits only |
| Prosthetic Devices* | $0 |
| Pulmonary Rehabilitation Services | $0 |
| Supervised Exercise Therapy (SET) for PAD | $0 |
| Radiation Therapy* | $0 |
| ***These benefits may require prior authorization.** | |

| ADDITIONAL PROGRAMS (not covered by Original Medicare) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS (not covered by Original Medicare)** | |
| Fitness Program | SilverSneakers® |
| Resources for Living® | This program is offered to help you locate resources for everyday needs. |
| Teladoc™ | $0<br>Telemedicine services with a Teladoc provider. State mandates may apply. |
| Telehealth Mental Health services provided by MD live | $0 |
| Telehealth PCP | $0 |
| Telehealth Specialist | $0 |
| Telehealth Occupational Therapy Service | $0 |
| Telehealth PT and SP Services | $0 |
| Telehealth Other Health Care Providers | $0 |
| Telehealth Individual Mental Health* | $0 |
| Telehealth Group Mental Health* | $0 |
| Telehealth Individual Psychiatric Services* | $0 |
| Telehealth Group Psychiatric Services* | $0 |
| Telehealth Individual Substance | $0 |

*This continues on the next page*

| ADDITIONAL PROGRAMS (not covered by Original Medicare) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS (not covered by Original Medicare)** (continued) | |
| Abuse Services* | |
| Telehealth Group Substance Abuse Services* | $0 |
| Telehealth Kidney Disease Education Services | $0 |
| Telehealth Diabetes Self-Management Training | $0 |
| Telehealth Opioid Treatment Program Services* | $0 |
| Telehealth Urgent Care | $0 |
| Physical Exam | $0<br>A routine physical exam is offered once per calendar year. |
| Wigs | $0 |
| Maximum | $400 |
| Frequency | one wig every year |
| ***These benefits may require prior authorization.** | |

## PHARMACY - PRESCRIPTION DRUG BENEFITS

| | |
|---|---|
| **Deductible** | **$100** |

Prescription drug calendar-year deductible must be satisfied before any Medicare prescription drug benefits are paid. Covered Medicare prescription drug expenses will accumulate toward the pharmacy deductible.

| | |
|---|---|
| **Pharmacy Network** | **P1** |

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (AetnaRetireePlans.com).

| | |
|---|---|
| **Formulary (Drug List)** | **Classic** |

## INITIAL COVERAGE LIMIT (ICL) $5,030

The Initial Coverage Limit includes the plan deductible, if applicable.

This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

| 4 Tier plan | 30-day Supply through Network Retail | | 90-day Supply through Network Retail or Mail | | |
|---|---|---|---|---|---|
| | Preferred | Standard | Preferred Retail | Preferred Mail | Standard Retail or Mail |
| **Tier 1** Generic drugs - Includes low-cost generic drugs | You pay $6 | You pay $18 | You pay $18 | You pay $18 | You pay $18 |
| **Tier 2** Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs | You pay 20% for your drug | You pay 25% for your drug | You pay 20% for your drug | You pay $70 | You pay 25% for your drug |

| 4 Tier plan | 30-day Supply through Network Retail | | 90-day Supply through Network Retail or Mail | | |
|---|---|---|---|---|---|
| | Preferred | Standard | Preferred Retail | Preferred Mail | Standard Retail or Mail |
| **Tier 3** Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs | You pay 20% for your drug | You pay 50% for your drug | You pay 20% for your drug | You pay $85 | You pay 50% for your drug |
| **Tier 4** Specialty drugs - Includes high-cost/unique brand and generic drugs | You pay 20% for your drug | You pay 20% for your drug | Limited to one-month supply | Limited to one-month supply | Limited to one-month supply |

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

**If you reside in a long-term care facility, your cost share is the same as a 30-day supply at a retail pharmacy and you may receive up to a 31-day supply.**

| COVERAGE GAP |
|---|
| The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost sharing for covered Part D drugs between the Initial Coverage Limit until you reach $8,000 in prescription drug expenses is indicated below. |

| CATASTROPHIC COVERAGE | |
|---|---|
| Catastrophic Coverage | You pay $0 for all covered Part D drugs. |
| Catastrophic Coverage benefits start once $8,000 in true out-of-pocket costs is incurred. | |

| REQUIREMENTS | |
|---|---|
| Precertification | Applies |
| Step Therapy | Applies |

## NON-PART D SUPPLEMENTAL BENEFIT

- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents when used for anorexia, weight loss, or weight gain
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## MEDICAL DISCLAIMERS

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

Participating 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.

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 AM to 9 PM ET, 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 Member Services 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.

## PHARMACY DISCLAIMERS

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **1-888-267-2637** (TTY: 711) or consult the online pharmacy directory at AetnaRetireePlans.com.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30-day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-866-241-0357 (TTY users should call 711), 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. You may have the option to sign up for automated mail-order delivery.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the Coverage Gap.

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

## PHARMACY DISCLAIMERS

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which an additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

**Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan.** Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the non-Part D supplemental drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered 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 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.

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.

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



To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a compliant to Medicare, call 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week). If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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

You can read the *Medicare & You 2024* 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 (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.

You can also visit our website at AetnaRetireePlans.com . As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

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



Y0001_GRP_5560_2024_M

September 2024

Form Approved
OMB#0938-1421

# Multi-Language Insert

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-267-2637. Someone who speaks English/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 1-888-267-2637. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-267-2637。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-267-2637。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-267-2637. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-267-2637. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-267-2637. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-267-2637. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-888-267-2637. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-267-2637. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-267-2637 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-267-2637. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-267-2637. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-267-2637. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-267-2637. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-267-2637. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-267-2637. にお電話ください。日本語を話す人 者が支援いたします。これは無料のサー ビスです。

**Hawaiian:** He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-888-267-2637. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

Y0001_NR_30475b_2023_C

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

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

**ESPAÑOL (SPANISH):** Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

傳統漢語(中文) **(CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。

# Labor Benefits Association

Sponsored by Aetna Medicare Plan (PPO)

(C05) ESA PPO Part B Only Plan, Rx $6/20%/20%/20%

## Keep in mind

This is just a summary. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). You can request a copy of the SOC/EOC by contacting:

**Member Services**

**1-888-267-2637** (TTY: 711)

Hours are 8 AM to 9 PM ET, Monday through Friday.

This is a summary of the services we cover from January 1, 2024 through December 31, 2024.

## Are you eligible to enroll?

**To join Aetna Medicare Plan (PPO), you must**:

- Be enrolled in Medicare Part B
- Live in the plan's service area

Service area: A complete list of service areas can be found in the *Evidence of Coverage* (EOC).

## What You Should Know

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

| Plan costs & information | Network & Out-of-network providers |
|---|---|
| Premium | Please contact your former employer/union/trust for more information on your plan premium. |
| Annual Deductible | $250<br>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. |
| Services Exempt from Deductible | Deductible waived for Preventive Services, Part B Drugs - Insulin, Continuous Glucose Monitors (CGM), Emergency Room Visits, Emergency Ambulance, Urgent Care, some Medicare-covered diagnostic tests and labs (Urine protein, Prothrombin testing, HBA1C, FIT Screening, Fundus Testing, gFOBT Testing and COVID lab tests), Wigs, and MDLive. |
| Annual Maximum Out-of-Pocket | $1,500<br>The maximum out-of-pocket (MOOP) is the **most you'll pay** for the medical services we cover each year. **It's in place to protect you**. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP. |

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Hospital Care*** | |
| Inpatient Hospital Care | $0 per stay<br>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. |
| Frequency: | per stay |
| Outpatient Hospital Services and Surgery | $0 |
| Ambulatory Surgery Center | $0 |
| **Physician Services** | |
| Primary Care Physician Visits | $25<br>Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery. |
| Physician Specialist Visits | $25 |
| **Preventive Services** | |
| Abdominal aortic aneurysm screenings | $0 |
| Alcohol misuse screenings and counseling | $0 |
| Annual well visit - one exam every 12 months | $0 |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Preventive Services** (continued) | |
| Bone mass measurements | $0 |
| Breast exams | $0 |
| Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; one annual mammogram for members age 40 and over | $0 |
| Cardiovascular behavior therapy | $0 |
| Cardiovascular disease screenings | $0 |
| Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | $0 |
| Depression screenings | $0 |
| Diabetes screenings | $0 |
| HBV infection screening | $0 |
| Hepatitis C screening tests | $0 |
| HIV screenings | $0 |
| Lung cancer screenings and counseling | $0 |
| Medicare Diabetes Prevention Program (MDPP) | $0 |
| Nutrition therapy services | $0 |
| Obesity behavior therapy | $0 |
| Pelvic exams - one routine GYN visit and Pap smear every 24 months | $0 |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Preventive Services** (continued) | |
| 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 | $0 |
| Prostate cancer screenings (PSA) - for all male patients aged 50 or older (coverage begins the day after 50th birthday) | $0 |
| Sexually transmitted infections screening and counseling | $0 |
| Tobacco use cessation counseling | $0 |
| "Welcome to Medicare" preventive visit | $0 |
| **Immunizations** | |
| Flu | $0 |
| Hepatitis B | $0 |
| Pneumococcal | $0 |
| **Additional Medicare Preventive Services** | |
| Barium enema - one exam every 12 months | $0 |
| Diabetes self-management training (DSMT) | $0 |
| Digital rectal exam (DRE) | $0 |
| *This continues on the next page* | |

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Additional Medicare Preventive Services** (continued) | |
| EKG following welcome exam | $0 |
| Glaucoma screening | $0 |
| **Emergency and Urgent Medical Care** | |
| Emergency Care (includes services worldwide) | $50 (waived if admitted immediately) |
| Urgent Care (includes services worldwide) | $25 |
| **Diagnostic Procedures*** | |
| Diagnostic Radiology (CT scans) | 20% |
| Diagnostic Radiology (other than CT scans) | 20% |
| Diagnostic Testing and Procedures | $0 |
| Lab Services | $0 |
| Outpatient X-rays | 20% |
| **Hearing Services** | |
| Hearing Exam (routine) | $0<br>Coverage: one exam every twelve months |
| Hearing Exam (Medicare-covered) | $25 |
| **Dental Services*** | |
| Dental Services | $25<br>Medicare-covered benefits only |
| **Vision Services** | |
| Eye Exam (routine) | $0 |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Vision Services** (continued) | |
| | Coverage: one exam every twelve months |
| Diabetic Eye Exam | $0 |
| Eye Exam (Medicare-covered) | $25 |
| **Mental Health Services*** | |
| Inpatient Mental Health Care | $0 per stay |
| | The member cost sharing applies to covered benefits incurred during a member's inpatient stay. |
| Outpatient Mental Health Care | $25 (individual sessions) |
| | $25 (group sessions) |
| Partial Hospitalization | $0 |
| Inpatient Substance Abuse | $0 per stay |
| | The member cost sharing applies to covered benefits incurred during a member's inpatient stay. |
| Outpatient Substance Abuse | $25 (individual sessions) |
| | $25 (group sessions) |
| **Skilled Nursing Services*** | |
| Skilled Nursing Facility (SNF) Care | 0% per day, days 1-100 |
| | Limited to 100 days per Medicare benefit period.<br>The member cost sharing applies to covered benefits incurred during a member's inpatient stay.<br>A benefit period begins the day you go into a hospital or skilled nursing |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Skilled Nursing Services*** (continued) | |
| | 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. |
| **Outpatient Rehabilitation Services** | |
| Occupational Therapy Rehabilitation Services | 20% |
| Physical and Speech Therapy Rehabilitation Services | 20% |
| **Ambulance* and Transportation Services** | |
| Ambulance Services | 20%<br>Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an |

*This continues on the next page*

| PRIMARY BENEFITS | Your costs for in and out-of-network care |
|---|---|
| **Ambulance* and Transportation Services** (continued) | |
| | out-of-network provider. |
| Transportation (non-emergency) | Not Covered |
| **Medicare Part B Prescription Drugs*** | |
| Medicare Part B Prescription Drugs | $0 |
| ***These benefits may require prior authorization.** | |

## Medicare Part D Prescription Drugs

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section on page 15 for your plan benefits at each Part D phase, including cost share and other important pharmacy benefit information.

| ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)** | |
| Acupuncture Services | $25<br>Medicare-covered benefits only |
| Allergy Shots | $0 |
| Allergy Testing | $25 |
| Blood | $0<br>All components of blood are covered beginning with the first pint. |
| Cardiac Rehabilitation Services | 20% |
| Chiropractic Services* | $20<br>Medicare-covered benefits only |
| Diabetic Supplies* | $0<br>Includes supplies to monitor your blood glucose from LifeScan, or from a non-preferred provider when a prior authorization is received. |
| Durable Medical Equipment (DME)* | 20% |
| Home Health Agency Care* | $0 |
| Hospice Care | Your hospice services at a Medicare-certified hospice facility are paid for by Aetna at 100%. |
| Intensive Cardiac Rehabilitation Services | 20% |
| Medical Supplies* | Your cost share is based upon the provider of |

*This continues on the next page*

| ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)**(Continued) | |
| | services |
| Outpatient Dialysis Treatments* | 20% |
| Podiatry Services | $25 |
| | Medicare-covered benefits only |
| Prosthetic Devices* | 20% |
| Pulmonary Rehabilitation Services | 20% |
| Supervised Exercise Therapy (SET) for PAD | 20% |
| Radiation Therapy* | 20% |
| ***These benefits may require prior authorization.** | |

| ADDITIONAL PROGRAMS (not covered by Original Medicare) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS (not covered by Original Medicare)** | |
| Fitness Program | SilverSneakers® |
| Resources for Living® | This program is offered to help you locate resources for everyday needs. |
| Teladoc™ | $0<br>Telemedicine services with a Teladoc provider. State mandates may apply. |
| Telehealth Mental Health services provided by MD live | $0 |
| Telehealth PCP | $25 |
| Telehealth Specialist | $25 |
| Telehealth Occupational Therapy Service | 20% |
| Telehealth PT and SP Services | 20% |
| Telehealth Other Health Care Providers | $25 |
| Telehealth Individual Mental Health* | $25 |
| Telehealth Group Mental Health* | $25 |
| Telehealth Individual Psychiatric Services* | $25 |
| Telehealth Group Psychiatric Services* | $25 |
| Telehealth Individual Substance | $25 |

*This continues on the next page*

| ADDITIONAL PROGRAMS (not covered by Original Medicare) | Your costs for in and out-of-network care |
|---|---|
| **ADDITIONAL PROGRAMS (not covered by Original Medicare)** (continued) | |
| Abuse Services* | |
| Telehealth Group Substance Abuse Services* | $25 |
| Telehealth Kidney Disease Education Services | $0 |
| Telehealth Diabetes Self-Management Training | $0 |
| Telehealth Opioid Treatment Program Services* | $25 |
| Telehealth Urgent Care | $25 |
| Physical Exam | $0<br>A routine physical exam is offered once per calendar year. |
| Wigs | $0 |
| Maximum | $400 |
| Frequency | one wig every year |
| ***These benefits may require prior authorization.** | |

## PHARMACY - PRESCRIPTION DRUG BENEFITS

| | |
|---|---|
| **Deductible** | **$200** |

Prescription drug calendar-year deductible must be satisfied before any Medicare prescription drug benefits are paid. Covered Medicare prescription drug expenses will accumulate toward the pharmacy deductible.

| | |
|---|---|
| **Pharmacy Network** | **P1** |

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (AetnaRetireePlans.com).

| | |
|---|---|
| **Formulary (Drug List)** | **Classic** |

| | |
|---|---|
| **INITIAL COVERAGE LIMIT (ICL)** | **$5,030** |

The Initial Coverage Limit includes the plan deductible, if applicable.

This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

| 4 Tier plan | 30-day Supply through Network Retail | | 90-day Supply through Network Retail or Mail | | |
|---|---|---|---|---|---|
| | Preferred | Standard | Preferred Retail | Preferred Mail | Standard Retail or Mail |
| **Tier 1** Generic drugs - Includes low-cost generic drugs | You pay $6 | You pay $18 | You pay $18 | You pay $18 | You pay $18 |
| **Tier 2** Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs | You pay 20% for your drug | You pay 25% for your drug | You pay 20% for your drug | You pay $70 | You pay 25% for your drug |

| 4 Tier plan | 30-day Supply through Network Retail | | 90-day Supply through Network Retail or Mail | | |
|---|---|---|---|---|---|
| | Preferred | Standard | Preferred Retail | Preferred Mail | Standard Retail or Mail |
| **Tier 3** Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs | You pay 20% for your drug | You pay 50% for your drug | You pay 20% for your drug | You pay $85 | You pay 50% for your drug |
| **Tier 4** Specialty drugs - Includes high-cost/unique brand and generic drugs | You pay 20% for your drug | You pay 20% for your drug | Limited to one-month supply | Limited to one-month supply | Limited to one-month supply |

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

**If you reside in a long-term care facility, your cost share is the same as a 30-day supply at a retail pharmacy and you may receive up to a 31-day supply.**

## COVERAGE GAP

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost sharing for covered Part D drugs between the Initial Coverage Limit until you reach $8,000 in prescription drug expenses is indicated below.

## CATASTROPHIC COVERAGE

| | |
|---|---|
| Catastrophic Coverage | You pay $0 for all covered Part D drugs. |

Catastrophic Coverage benefits start once $8,000 in true out-of-pocket costs is incurred.

| REQUIREMENTS | |
|---|---|
| Precertification | Applies |
| Step Therapy | Applies |

## NON-PART D SUPPLEMENTAL BENEFIT

- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents when used for anorexia, weight loss, or weight gain
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

## MEDICAL DISCLAIMERS

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

Participating 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.

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 AM to 9 PM ET, 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 Member Services 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.

## PHARMACY DISCLAIMERS

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **1-888-267-2637** (TTY: 711) or consult the online pharmacy directory at AetnaRetireePlans.com.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30-day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-866-241-0357 (TTY users should call 711), 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. You may have the option to sign up for automated mail-order delivery.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the Coverage Gap.

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

## PHARMACY DISCLAIMERS

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which an additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

**Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan.** Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the non-Part D supplemental drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered 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 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.

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.

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



To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a compliant to Medicare, call 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week). If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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

You can read the *Medicare & You 2024* 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 (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.

You can also visit our website at AetnaRetireePlans.com . As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

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



Y0001_GRP_5560_2024_M

September 2024

Form Approved
OMB#0938-1421

# Multi-Language Insert

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-267-2637. Someone who speaks English/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 1-888-267-2637. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-267-2637。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-267-2637。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-267-2637. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-267-2637. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-267-2637. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-267-2637. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-888-267-2637. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-267-2637. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-267-2637 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-267-2637. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-267-2637. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-267-2637. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-267-2637. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-267-2637. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-267-2637. にお電話ください。日本語を話す人 者が支援いたします。これは無料のサー ビスです。

**Hawaiian:** He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-888-267-2637. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

Y0001_NR_30475b_2023_C

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

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

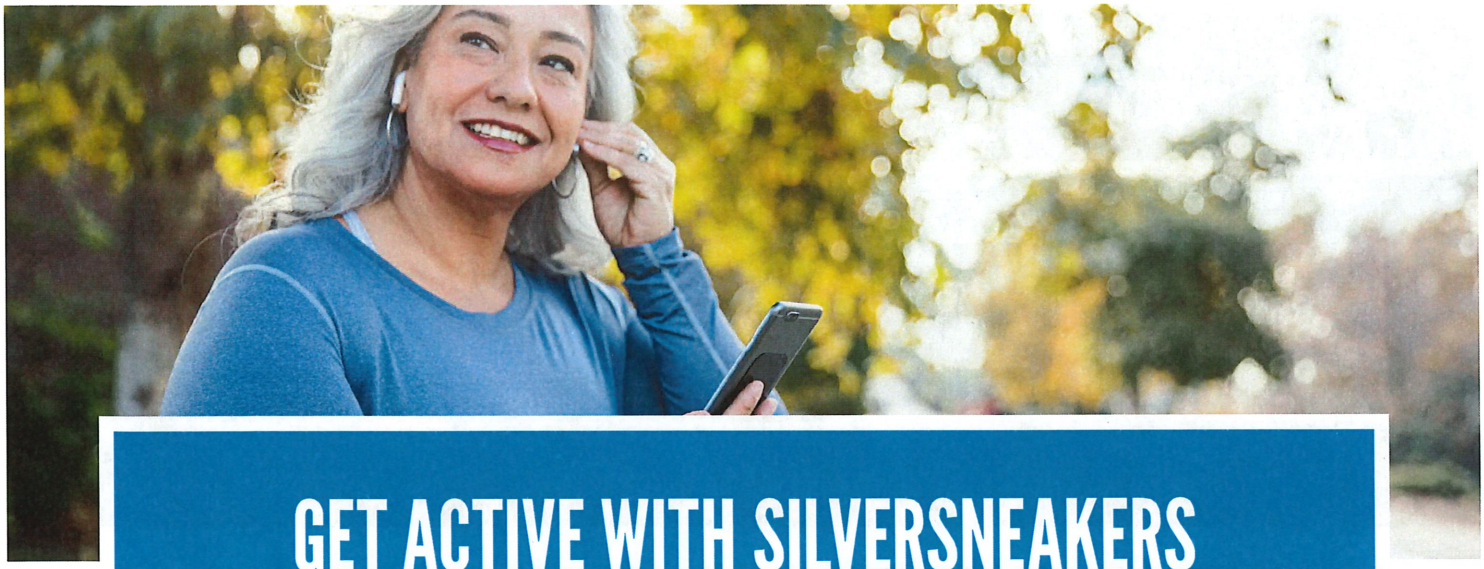
In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

**ESPAÑOL (SPANISH):** Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

傳統漢語(中文) **(CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。



# GET ACTIVE WITH SILVERSNEAKERS

SilverSneakers® is more than a fitness program. It's an opportunity to improve your health, gain confidence and connect with your community. Plus, it's included **at no additional cost** in your health plan.

With SilverSneakers, you're free to move in the ways that work for you.

## In participating fitness locations

- Thousands of participating locations[1] with various amenities
- Ability to enroll at multiple locations at any time
- SilverSneakers classes[2] designed for all levels

## In your community

- Group activities and classes[2] offered outside the gym
- Events including shared meals, holiday celebrations and class socials

## At home or on the go

- SilverSneakers LIVE™ virtual classes and workshops throughout the week
- SilverSneakers On-Demand™ fitness classes available 24/7
- SilverSneakers GO™ mobile app with adjustable workout plans and more

**Did you know?**

**88%**

of participants say SilverSneakers has improved their quality of life.[3]

**You already have SilverSneakers through your health plan.**
You just need your member ID to get started. See other side for more details.

***SilverSneakers.com/StartHere***

**Questions? Call us.**
**1-888-423-4632** (TTY: **711**) Monday – Friday 8 a.m. – 8 p.m. ET

SilverSneakers®

# LET'S GET STARTED!

## Get your SilverSneakers Member ID

If you're new to SilverSneakers, go to **SilverSneakers.com/StartHere** and follow the simple steps.

If you're already a member, log in to the **Member Portal** at **SilverSneakers.com** and click **Profile/Member ID**.

My SilverSneakers **ID number**

**Write your ID number in the spaces provided.** You can either cut this out or take a photo with your phone so you always have your ID with you.

Notes:

**Get inspired!**
Scan to learn more about SilverSneakers or visit **SilverSneakers.com/AboutUs**

SilverSneakers

**Always talk with your doctor before starting an exercise program.**

1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.
3. 2021 SilverSneakers Annual Participant Survey

# For your doctor

**Provider—Keep this flyer with your patient's file**

## Dear Provider,

Your patient is a member of the Aetna Medicare℠ Plan (PPO) with Extended Service Area (ESA)–also known as the Aetna Medicare Advantage plan.

Aetna is a retiree benefits health plan partner. This retiree will be a member of the Aetna Medicare Advantage PPO ESA. This unique, customized group plan is only available to members whose former employer sponsors these plans.

Just read this information sheet to learn how Aetna Medicare makes it easy for your patients to continue seeing you under our plan, regardless of whether you are in our network.

If you have questions after using the resources, just call **1-800-624-0756**, Monday–Friday, 8 AM–5 PM local time.

**You can see Aetna Medicare Advantage members even if you're not part of our network.**

## Here's the Aetna ID card your patient should have

aetna — Medicare PPO

LBA Medicare ESA PPO
PREMIER PLAN
PLAN# XXX-EG00000000X
**ID 101XXXXXXXXX**
NAME SAMPLE SAMPLETON
RxBIN 610502 RxPCN MEDDAET
RxGRP# RXAETD

MedicareRx Prescription Drug Coverage

ISSUER (80840)
PCP/Office Name:
Dr. Sample
999-999-9999 XXXXXXXXX

PCP $xx
ER $xx
AS $xx
HO $xx/A
SP $xx

Printed on: xx/xx/xxxx

H5521-802

AetnaRetireePlans.com

| | |
|---|---|
| Customer Service | 1-888-267-2637 |
| Prescription Drug | 1-866-241-0357 |
| 24 Hour Nurse Line | 1-855-493-7019 |
| Provider Services | 1-800-624-0756 |
| TDD/TTY | 711 |

Send claims to:
Aetna Medicare
PO Box 981106
El Paso, TX 79998-1106

This card does not guarantee coverage.

Payer ID# 60054



aetna

# What you need to know

- If you already participate with Aetna®, the terms of your agreement apply.
- If you **don't currently participate with Aetna, no contract** is required to see patients enrolled in the group Medicare Advantage plan.
- We encourage you to join our network; you'll find **it's easy to work with us**.
- This plan covers all **Original Medicare benefits and more**, including many preventive services.
- Referrals are **not** required.
- Precertification is recommended, but **not** required.
- You should collect the copayment, coinsurance and/or deductible for covered services as shown on your patient's Aetna Medicare Advantage ID card.
- Billing is simplified. Submit one bill to Aetna and receive one remittance.
- Reimbursement is simple and easy.
- The Medicare fee schedule and Medicare limiting charges will apply.

## What we pay you:

- Medicare-allowable rates for clean claims on covered services under your patient's plan
- Less the patient cost share (copayment, coinsurance and/or deductible) under your patient's plan

# How to bill Aetna

Include the patient-paid amount on claims submitted to us. Claims will be processed based on:

- Original Medicare billing rules
- Medicare fee schedule and Medicare limiting charges
- All prospective payment system requirements
- Local coverage determinations
- The patient's plan documents, including their Evidence of Coverage
- With respect to bundling/unbundling logic, we use the National Correct Coding Initiative (NCCI). The link to NCCI on the Centers for Medicare & Medicaid Services (CMS) website is **CMS.gov/nationalcorrectcodinited/**.

### Electronic claims submission

Use our electronic payer **ID #60054.**

### Paper claims submission

Submit all paper claims for covered services using an Aetna claim form or by using the standard CMS-1500 or UB-04 form and send to:

**Aetna**
**PO Box 981106**
**El Paso, TX 79998-1106**

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

**AetnaRetireePlans.com**


GRP_4010_2205a_M
58.02.325.1-PROVIDER-B (10/23)

aetna®