Aetna Life Insurance Company

Former Employer/Union/Trust Name: **The Dow Chemical Company**
Group Agreement Effective Date: **01/01/2021**
Group/Account Number: **461872, 461908**

This Schedule of Cost Sharing is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the attachment for information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.) If you have questions, please call Member Services at the telephone number listed on your member ID card.

Annual Deductible	
This is the amount you have to pay out-of-pocket before the plan will pay its share for your covered Medicare Part A and B services.	**No Deductible**
Annual Maximum Out-of-Pocket Limit	
The maximum out-of-pocket limit is the most you will pay for covered benefits including any deductible (if applicable).	Combined maximum out-of-pocket amount for in- and out-of-network services: **$2,500**

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

If you receive services from:	If your plan services include:	You will pay:
A primary care physician (PCP) or specialist and get more than one covered service during the single visit: *A clinic visit cost share may apply based on the role of the attending physician (PCP or specialist)*	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.
An outpatient facility and get more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

Medical Benefits Chart

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

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
	Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	You pay a $25 copay for each Medicare-covered acupuncture visit.
	Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are	You pay a $150 copay for each Medicare-covered one-way trip.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required **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.**	
	Annual routine physical The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" preventive visit. You may schedule your annual routine physical once per calendar year. Preventive labs, screenings, and/or diagnostic tests received during this visit are subject to your lab and diagnostic test coverage. Please see "**Outpatient diagnostic tests and**	You pay a $0 copay for the exam.

Services that are covered for you		What you must pay (after any deductible listed on page 1) when you get these services
	therapeutic services and supplies" for more information.	
	Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
	Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
	Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms. There is no coinsurance, copayment, or deductible for diagnostic mammograms.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay a $25 copay for each Medicare-covered cardiac rehabilitation visit.
	Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
	Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
	Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $20 copay for each Medicare-covered visit.
	Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If a polyp is removed or a biopsy is performed during a Medicare-covered screening colonoscopy, the polyp removal and associated pathology, will be covered at $0 copay as these procedures were during a preventive service. If you have had polyps removed during a previous colonoscopy or have a prior history of colon cancer, ongoing colonoscopies are considered diagnostic, are not considered preventive screenings, and are subject to the outpatient surgery cost-sharing. (See "**Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**" for more information.)

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Medicare-covered services include: • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered (non-routine) dental care service.
	Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
	Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. You should order your LifeScan starter kit including the model of meter you prefer by contacting LifeScan directly at 1-877-764-5390. Use order code: 123AET200. LifeScan will send you a starter kit in the mail that includes the meter you selected, a small supply of lancets and test strips, as well as usage and educational materials. You should also reach out to your physician to obtain a prescription for LifeScan test strips that you can fill at your network pharmacy.	We cover diabetic supplies made by OneTouch/ LifeScan. We exclusively cover OneTouch/ LifeScan glucose monitors and test strips. We also cover OneTouch/LifeScan lancets, solutions, and lancing devices. We do not cover other brands of monitors and test strips unless you or your provider requests a medical exception and it is approved. Non-LifeScan monitors and test strips without a medical exception, or a medical exception that is not approved, will not be covered. You pay a $0 copay for each Medicare-covered diabetic service or supply from OneTouch/ Lifescan, or from a non-preferred provider when a prior authorization is received. You pay a $0 copay for each pair of Medicare-covered diabetic shoes/inserts. $0 copay for members eligible for the Medicare-covered diabetes self-management training preventive benefit.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Prior authorization rules may apply. Your network provider is responsible for requesting prior authorization.	
	Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at Dow.aetnamedicare.com **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay 20% of the total cost for each Medicare-covered item.
	Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	You pay a $65 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, your cost sharing amount for the emergency room visit will be waived.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. This coverage is available worldwide (i.e., outside of the United States).	
	Health and wellness education programs • **Aetna Healthy Rewards** The Aetna Healthy Rewards program is a highly personalized incentive and rewards program. Plan members can earn rewards in the form of merchandise gift cards by completing specific health and wellness activities within the plan year. Coinsurance, copayment or deductible may apply to the medical service completed in order to earn the reward. There is no out of pocket cost to the member to redeem the reward once the required activity is complete. • **Fitness Benefit** You are covered for a basic membership to a SilverSneakers® participating fitness facility. At-home fitness kits and online classes are also available for members that do not reside near a participating club or prefer to exercise at home. Members may order one fitness kit per year.	Included in your plan. SilverSneakers® Fitness Program is included in your plan. There is no coinsurance, copayment, or deductible for this service. We're here to help and give you more information. • Call us at **1-888-423-4632**. (For TTY/TDD assistance please dial 711.) • Visit www.silversneakers.com to find a participating location near you.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• **24-Hour Nurse Line** Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options.	Included in your plan. There is no coinsurance, copayment, or deductible for the 24-Hour Nurse Line service. Call us at **1-800-556-1555**.(For TTY/TDD assistance please dial 711.)
• **Resources for Living ℠** Resources for Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life related issues.	Included in your plan. There is no coinsurance, copayment, or deductible for this service. Call Resources for Living at **1-866-370-4842**.
• **Written health education materials** Written health education materials, such as plan issued newsletters and websites, and information on community resources.	Included in your plan.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	You pay a $25 copay for each Medicare-covered hearing and balance evaluation.
• Our plan covers one non-Medicare covered hearing exam every 12 months	You pay a $0 copay for the non-Medicare covered hearing exam.
• Hearing aid reimbursement You may see any licensed hearing provider who accepts Medicare patients in the U.S. and has not opted out of Original Medicare. You pay the provider for services and submit an itemized billing statement showing proof of payment to our plan. You must submit your	Our plan will reimburse you up to $500 once every 36 months towards the cost of hearing aids.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	documentation within 365 days from the date of service to be eligible for reimbursement. If approved, it can take up to 45 days for you to receive payment. If your request is incomplete, such as no itemization of services, or there is missing information, you will be notified by mail. You will then have to supply the missing information, which will delay the processing time. Notes: If you use a non-licensed provider you will not receive reimbursement. If you use a provider that has opted out of Medicare you will not receive reimbursement. You are responsible for any charges above the reimbursement amount. Amounts you pay for hearing aids do not count toward your annual maximum out-of-pocket amount.	
	HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
	Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.	You pay a $0 copay for each Medicare-covered home health visit. You pay 20% of the total cost for each Medicare-covered durable medical equipment item.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You pay a $25 copay for Medicare-covered home infusion therapy professional services, training and education, and monitoring. Please note that home infusion drugs, pumps and devices provided during a home infusion therapy visit are covered separately under your "DME and related supplies" benefit.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, you pay your plan cost-sharing amount for these services. For services that are covered by our plan but are not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*) of your *Evidence of Coverage*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Hospice consultations are included as part of **Inpatient Hospital Care**. Physician service cost sharing may apply for outpatient consultations.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. You pay a $0 copay for other Medicare-covered Part B vaccines. You may have to pay an office visit cost-share if you get other services at the same time that you get vaccinated.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of days covered by our plan. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy	For Medicare-covered hospital stays, you pay: $200 copay per day, day(s) 1-7 $0 copay for additional days. Cost-sharing is charged for each inpatient stay.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web	

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Inpatient mental health care • Covered services include mental health care services that require a hospital stay • There is no limit to the number of days covered by our plan **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	For Medicare-covered hospital stays, you pay: $200 copay per day, day(s) 1-7 $0 copay for additional days. Cost-sharing is charged for each inpatient stay.
	Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your skilled nursing facility (SNF) benefits or if the SNF or inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests)	You pay a $15 copay for each Medicare-covered primary care doctor visit. You pay a $25 copay for each Medicare-covered specialist visit. You pay a $25 copay for each Medicare-covered diagnostic procedure or test. You pay a $25 copay for each Medicare-covered lab service. You pay a $25 copay for each Medicare-covered X-ray.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $25 copay for each Medicare-covered therapeutic radiology service. You pay a $15 copay for Medicare-covered medical supply items received from a PCP. You pay a $25 copay for Medicare-covered medical supply items received from other providers. You pay 20% of the total cost for each Medicare-covered prosthetic and orthotic item. You pay 20% of the total cost for each Medicare-covered DME item. You pay a $25 copay for each Medicare-covered physical, speech or occupational therapy visit.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-	You pay a $0 copay per prescription or refill. You pay a $0 copay for each chemotherapy or infusion therapy Part B drug. You pay a $25 copay for the administration of the chemotherapy drug as well as for infusion therapy.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Part B drugs may be subject to step therapy requirements. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: aetna.com/partb-step. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 of the *Evidence of Coverage*. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings	Your cost-share is based on: • the tests/services/ supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed You pay a $25 copay for each Medicare-covered X-ray.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Diagnostic radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. All components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $25 copay for each Medicare-covered lab service. You pay a $25 copay for each Medicare-covered diagnostic procedure or test. You pay a $25 copay for each Medicare-covered therapeutic radiology service. You pay a $15 copay for Medicare-covered medical supply items received from a PCP. You pay a $25 copay for Medicare-covered medical supply items received from other providers.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.	Your cost share for Observation Care is based upon the Medicare-covered services you receive.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an	You pay a $200 copay per facility visit. Your cost-share is based on: • the tests/services/ supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed You pay a $15 copay for each Medicare-covered primary care doctor visit. You pay a $25 copay for each Medicare-covered specialist visit. You pay a $25 copay for each Medicare-covered lab service. You pay a $25 copay for each Medicare-covered diagnostic procedure and test. You pay a $25 copay for each Medicare-covered mental health service (individual session). You pay a $25 copay for each Medicare-covered mental health service (group session). You pay a $25 copay for each Medicare-covered X-ray.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
"outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered diagnostic radiology and complex imaging service. You pay a $25 copay for each Medicare-covered therapeutic radiology service. You pay a $25 copay for each Medicare-covered partial hospitalization visit. You pay a $15 copay for Medicare-covered medical supply items received from a PCP. You pay a $25 copay for Medicare-covered medical supply items received from other providers. You pay a $0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself. You pay a $65 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, your cost sharing amount for the emergency room visit will be waived.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. We also cover some telehealth visits with psychiatric and mental health professionals. See "**Physician/Practitioner services, including doctor's office visits**" for	You pay a $25 copay for each Medicare-covered mental health service (individual session). You pay a $25 copay for each Medicare-covered mental health service (group session).

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
information about telehealth outpatient mental health care. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered outpatient rehabilitation service visit.
Outpatient substance abuse services Our coverage is the same as Original Medicare which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.	For each Medicare-covered outpatient substance abuse session, you pay $25

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief interventions or advice focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	Your cost-share is based on: • the tests/services/supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed. You pay a $200 copay for each Medicare-covered outpatient hospital facility visit. You pay a $200 copay for each Medicare-covered ambulatory surgical center visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay a $25 copay for each Medicare-covered visit.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: o Primary care physician services o Mental health services (individual sessions) o Mental health services (group sessions) o Psychiatric services (individual sessions) o Psychiatric services (group sessions) o Urgently needed services	Your cost-share is based on: • the tests/services/ supplies you receive • the provider of the tests/services/ supplies • the setting where the tests/services/ supplies are performed You pay a $15 copay for each Medicare-covered primary care doctor visit (including telehealth services, nationally contracted walk-in clinic services, and urgently needed services). You pay a $25 copay for each Medicare-covered specialist visit (including surgery second opinion, telehealth services, and urgently needed services). You pay a $25 copay for each Medicare-covered hearing and balance exam. Certain additional telehealth services, including those for: You pay a $15 copay for each primary care physician service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
○ This coverage is in addition to the telehealth services described below. For more details on your additional telehealth coverage, please review the Aetna Medicare Telehealth Coverage Policy at AetnaMedicare.com/Telehealth. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ○ Members should contact their doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a MinuteClinic Video Visit. Members can find out if these visits are available in their area at www.cvs.com/minuteclinic/virtual-care/video-visit. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:**	You pay a $25 copay for each mental health service (individual sessions). You pay a $25 copay for each mental health service (group sessions). You pay a $25 copay for each psychiatric service (individual sessions). You pay a $25 copay for each psychiatric service (group sessions). You pay a $50 copay for each urgently needed service. You pay a $25 copay for each Medicare-covered (non-routine) dental care service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	You pay a $25 copay for each Medicare-covered podiatry service.
	Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
	Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	You pay 20% of the total cost for each Medicare-covered item.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay a $25 copay for each Medicare-covered pulmonary rehabilitation visit.
	Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
	Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
	Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
	Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney	You pay a $0 copay for self-dialysis training and kidney disease education services. You pay a $25 copay for in- and out-of area outpatient dialysis.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the Evidence of Coverage) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs." **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider.**	See "**Inpatient Hospital Care**" for more information on Inpatient services You pay 20% of the total cost for home dialysis equipment and supplies. You pay a $0 copay for Medicare-covered home support services.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") We cover 100 days per benefit period. A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-**	For Medicare-covered SNF stays, you pay: $0 copay per day, day(s) 1-20, $100 copay per day, day(s) 21-100 A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	authorization of the service when provided by an out-of-network provider.	
	Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
	Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits	You pay a $25 copay for each Medicare-covered session.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Coverage is available worldwide (i.e., outside of the United States).	You pay a $50 copay for each Medicare-covered urgent care visit received at an urgent care facility. You pay a $50 copay for each Medicare-covered urgent care telehealth service.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older	You pay a $25 copay for exams to diagnose and treat diseases and conditions of the eye. You pay a $0 copay for one glaucoma screening every 12 months.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	• For people with diabetes, screening for diabetic retinopathy is covered once per year	You pay a $0 copay for one diabetic retinopathy screening every 12 months.
	• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	You pay a $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals.
	Our plan covers one non-Medicare covered eye exam every 12 months.	You pay a $0 copay for one non-Medicare covered eye exam.
	"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

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

Aetna Life Insurance Company

Former Employer/Union/Trust Name: The Dow Chemical Company
Group Agreement Effective Date: 01/01/2021
Group/Account Number: 461872

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

Annual Deductible Amount:	$0
Formulary Type:	GRP B2
Number of Cost Share Tiers:	4 Tier
Initial Coverage Limit:	$4,130
True Out-of-Pocket Amount:	$6,550
Maximum Out-of-Pocket Amount	$3,100
Once your individual out-of-pocket expenses reach this amount, you will pay $0 for all covered prescription drugs for the remainder of the plan year.	
Retail Pharmacy Network: S2 The name of your pharmacy network is listed above. When you get a 90-day fill of covered drugs at a retail pharmacy, your network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing: **you will pay a lower cost share at CVS Pharmacy retail locations for up to a 90-day fill of covered drugs compared to other network retail pharmacies.** To find a network pharmacy, you can look in your Pharmacy Directory, visit our website (www.AetnaRetireePlans.com), or call Customer Service (phone numbers are printed on your member ID card).	

Enhanced Drug Benefit

We offer additional coverage for some prescription drugs not normally covered in a Medicare prescription drug plan, including the following:

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

The cost share for these drugs is listed in the table below. See Tier 1 for the generic cost share amount and Tier 2 for the brand cost share amount. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. Limitations, such as quantity limits and prior authorization requirements, can be found in the formulary (Drug List) that is available online. In addition, if you are receiving "Extra Help" from Medicare to pay for your prescriptions, the "Extra Help" will not pay for these drugs. Please refer to your formulary or call Member Services for more information.

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

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

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

Initial Coverage Stage: Amount you pay, up to $4,130 in total covered prescription drug expenses **including your plan's preferred arrangement with CVS Retail pharmacy locations**.

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

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order or CVS Retail cost sharing** (up to a 90-day supply)
Tier 4 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay 33% for your drug	You pay 33% for your drug	You pay 33% for your drug	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Coverage Gap Stage: Amount you pay after you reach $4,130 in total covered prescription drug expenses and until you reach $6,550 in out-of-pocket covered prescription drug costs.

Your plan's gap coverage is listed in the chart below.

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost sharing** (up to a 90-day supply)	**Preferred mail order or CVS Retail cost sharing** (up to a 90-day supply)
Tier 1 Generic drugs - Includes low-cost generic drugs	You pay $5	You pay $5	You pay $5	You pay $15	You pay $10
Tier 2 Preferred brand drugs - Includes brand drugs and some high-cost generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug
Tier 3 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug
Tier 4 Specialty drugs - Includes high-cost/ unique brand and generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	Limited to one-month supply	Limited to one-month supply

*****Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

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

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

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2021, that amount is $6,550. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching $6,550 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	You pay $0 We will pay the rest.

Step Therapy

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

This Plan Uses the GRP B2 Formulary:

Your plan uses the GRP B2 formulary, which means that only drugs on Aetna's drug list will be covered under your plan as long as the drug is medically necessary, and the plan rules are followed. Tiers labeled as brand, preferred brand, and non-preferred drug will also include some high-cost generic drugs. Non-preferred copayment levels may apply to some drugs on the drug list. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2021 Group Formulary (List of Covered Drugs)* for more information.