January 1, 2010 to December 31, 2010

Summary of Benefits

Aetna Medicare℠ Plan (PPO) H5521

Connecticut

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Section 1: Introduction

Connecticut

Thank you for your interest in Aetna Medicare Plan (PPO). Our plan is offered by AETNA LIFE INSURANCE COMPANY/Aetna Medicare, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Aetna Medicare and ask for the "Evidence of Coverage."

You Have Choices In Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Aetna Medicare Plan (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Aetna Medicare at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare Aetna Medicare Plan (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where Is Aetna Medicare Plan (PPO) Available?

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

The service area for this plan includes: Fairfield, Hartford, Litchfield, New Haven Counties, CT. You must live in one of these areas to join the plan.

Who Is Eligible To Join Aetna Medicare Plan (PPO)?

You can join Aetna Medicare Plan (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with end-stage renal disease are generally not eligible to enroll in Aetna Medicare Plan (PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Aetna Medicare Plan (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at www.aetna.com/docfind/.

Our Customer Service number is listed at the end of this introduction.

What Happens If I Go To A Doctor Who's Not In Your Network?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the Customer Service number at the end of this introduction.

Does My Plan Cover Medicare Part B Or Part D Drugs?

Aetna Medicare Plan (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where Can I Get My Prescriptions If I Join This Plan?

Aetna Medicare Plan (PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.aetnamedicare.com. Our customer service number is listed at the end of this introduction.

What Is A Prescription Drug Formulary?

Aetna Medicare Plan (PPO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.aetnamedicare.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How Can I Get Extra Help With My Prescription Drug Plan Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- your state Medicaid office.

What Are My Protections In This Plan?

All Medicare Advantage plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Aetna Medicare Plan (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidign 1-800-553-7590.

As a member of Aetna Medicare Plan (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidign 1-800-553-7590.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Aetna Medicare for more details.

What Types Of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Aetna Medicare for more details.

- Some antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (epoetin alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia clotting factors: Self-administered clotting factors if you have hemophilia.
- Injectable drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some oral cancer drugs: If the same drug is available in injectable form.
- Oral anti-nausea drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

Plan Ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-282-5366 to obtain a copy of the plan ratings for this plan. TTY/TDD users call 1-888-760-4748.

Please call Aetna Medicare for more information about Aetna Medicare (PPO) Plan.

Visit us at www.aetnamedicare.com or, call us:

Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,
8:00 a.m. - 8:00 p.m.

Current members should call toll-free 1-800-282-5366 for questions related to the Medicare Advantage Program. (TTY/TDD 1-888-760-4748)

Prospective members should call toll-free 1-800-832-2640 for questions related to the Medicare Advantage Program. (TTY/TDD 1-888-760-4748)

Current members should call toll-free 1-800-282-5366 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-888-760-4748)

Prospective members should call toll-free 1-800-832-2640 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-888-760-4748)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

Section 2

Connecticut

If you have any questions about this plan's benefits or costs, please contact Aetna Medicare for details.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
IMPORTANT INFORMATION			
1 – Premium and Other Important Information	In 2009 the monthly Part B premium was $96.40 and will change for 2010 and the yearly Part B deductible amount was $135 and will change for 2010. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was $85,000 for singles, $170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $82 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $5,000 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Services/ Surgery • Ambulance Services • Emergency Care • Outpatient Rehabilitation Services • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End-Stage Renal Disease • Dental Services • Hearing Services • Vision Services • Physical Exams • Health/Wellness Education • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization	**General** $143 monthly plan premium in addition to your monthly Medicare Part B premium. **In-Network** $3,500 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Services/ Surgery • Ambulance Services • Emergency Care • Outpatient Rehabilitation Services • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End-Stage Renal Disease • Dental Services • Hearing Services • Vision Services • Physical Exams • Health/Wellness Education • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
1 – Premium and Other Important Information (continued)		• Other Health Care Professional • Diagnostic Procedures/ Test/Lab Benefits • Diagnostic/Therapeutic Radiological Services • Cardiac Rehabilitation Services • Blood • Nutrition Therapy for Diabetes and Renal Disease • Medicare Part B Rx Drugs This limit includes only Medicare-covered services. **Out-of-Network** $1,000 yearly deductible. Contact the plan for services that apply. $5,000 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Services/ Surgery • Ambulance Services • Urgently Needed Care • Outpatient Rehabilitation Services • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams	• Other Health Care Professional • Diagnostic Procedures/ Test/Lab Benefits • Diagnostic/Therapeutic Radiological Services • Cardiac Rehabilitation Services • Blood • Nutrition Therapy for Diabetes and Renal Disease • Medicare Part B Rx Drugs This limit includes only Medicare-covered services. **Out-of-Network** $1,000 yearly deductible. Contact the plan for services that apply. $3,500 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: • Home Health Care • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Services/ Surgery • Ambulance Services • Urgently Needed Care • Outpatient Rehabilitation Services • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
1 – Premium and Other Important Information (continued)		• Prostate Cancer Screening Exams • End-Stage Renal Disease • Dental Services • Hearing Services • Vision Services • Physical Exams • Health/Wellness Education • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Other Health Care Professional • Diagnostic Procedures/ Test/Lab Benefits • Diagnostic/Therapeutic Radiological Services • Cardiac Rehabilitation Services • Blood • Nutrition Therapy for Diabetes and Renal Disease • Medicare Part B Rx Drugs This limit includes only Medicare-covered services.	• Prostate Cancer Screening Exams • End-Stage Renal Disease • Dental Services • Hearing Services • Vision Services • Physical Exams • Health/Wellness Education • Comprehensive Outpatient Rehabilitation Facility (CORF) • Partial Hospitalization • Other Health Care Professional • Diagnostic Procedures/ Test/Lab Benefits • Diagnostic/Therapeutic Radiological Services • Cardiac Rehabilitation Services • Blood • Nutrition Therapy for Diabetes and Renal Disease • Medicare Part B Rx Drugs This limit includes only Medicare-covered services.
2 – Doctor and Hospital Choice (For more information, see Emergency Care – #15 and Urgently Needed Care – #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals.	**In-Network** No referral required for network doctors, specialists, and hospitals.
SUMMARY OF BENEFITS			
INPATIENT CARE			
3 – Inpatient Hospital Care (includes substance abuse and rehabilitation services)	In 2009 the amounts for each benefit period were: Days 1-60: $1068 deductible. Days 61-90: $267 per day. Days 91-150: $534 per lifetime reserve day. These amounts will change for 2010.	**In-Network** For Medicare-covered hospital stays: Days 1-7: $150 copay per day. Days 8-90: $0 copay per day. $0 copay for additional hospital days.	**In-Network** For Medicare-covered hospital stays: Days 1-7: $75 copay per day. Days 8-90: $0 copay per day. $0 copay for additional hospital days.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
3 – Inpatient Hospital Care (continued)	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	No limit to the number of days covered by the plan each benefit period. **Out-of-Network** 30% of the cost for each hospital stay.	No limit to the number of days covered by the plan each benefit period. **Out-of-Network** 30% of the cost for each hospital stay.
4 – Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care – #3" above). 190 day lifetime limit in a psychiatric hospital.	**In-Network** For Medicare-covered hospital stays: Days 1-7: $150 copay per day. Days 8-90: $0 copay per day. You get up to 190 days in a Psychiatric Hospital in a lifetime. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** For Medicare-covered hospital stays: Days 1-7: $75 copay per day. Days 8-90: $0 copay per day. You get up to 190 days in a Psychiatric Hospital in a lifetime. **Out-of-Network** 30% of the cost for each hospital stay.
5 – Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1-20: $0 per day. Days 21-100: $133.50 per day. These amounts will change for 2010. 100 days for each benefit period.	**In-Network** For SNF stays: Days 1-20: $0 copay per day. Days 21-100: $100 copay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required.	**In-Network** For SNF stays: Days 1-20: $0 copay per day. Days 21-100: $100 copay per day. Plan covers up to 100 days each benefit period. No prior hospital stay is required.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
5 – Skilled Nursing Facility (SNF) (continued)	A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**Out-of-Network** 30% of the cost for each SNF stay.	**Out-of-Network** 30% of the cost for each SNF stay.
6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc.)	$0 copay.	**In-Network** $0 copay for each Medicare-covered home health visit. **Out-of-Network** 30% for home health visits.	**In-Network** $0 copay for each Medicare-covered home health visit. **Out-of-Network** 30% for home health visits.
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.
OUTPATIENT CARE			
8 – Doctor Office Visits	20% coinsurance.	**General** See "Physical Exams – #33," for more information. **In-Network** $15 to $30 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $30 copay for each specialist visit for Medicare-covered benefits.	**General** See "Physical Exams – #33," for more information. **In-Network** $5 to $20 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $20 copay for each specialist visit for Medicare-covered benefits.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
8 – Doctor Office Visits (continued)		**Out-of-Network** 30% for each primary care doctor visit. 30% for each specialist visit.	**Out-of-Network** 30% for each primary care doctor visit. 30% for each specialist visit.
9 – Chiropractic Services	Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $30 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** 30% of the cost for chiropractic benefits.	**In-Network** $20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** 30% of the cost for chiropractic benefits.
10 – Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $30 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for podiatry benefits.	**In-Network** $20 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for podiatry benefits.
11 – Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	**In-Network** $30 copay for each Medicare-covered individual or group therapy visit. **Out-of-Network** 30% of the cost for Mental Health benefits. 30% of the cost for Mental Health benefits with a psychiatrist.	**In-Network** $20 copay for each Medicare-covered individual or group therapy visit. **Out-of-Network** 30% of the cost for Mental Health benefits. 30% of the cost for Mental Health benefits with a psychiatrist.
12 – Outpatient Substance Abuse Care	20% coinsurance.	**In-Network** $30 copay for Medicare-covered individual or group visits.	**In-Network** $20 copay for Medicare-covered individual or group visits.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
12 – Outpatient Substance Abuse Care (continued)		**Out-of-Network** 30% of the cost for outpatient substance abuse benefits.	**Out-of-Network** 30% of the cost for outpatient substance abuse benefits.
13 – Outpatient Services/Surgery	20% coinsurance for the doctor. 20% of outpatient facility charges.	**In-Network** $175 copay for each Medicare-covered ambulatory surgical center visit. $175 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** 30% of the cost for ambulatory surgical center benefits. 30% of the cost for outpatient hospital facility benefits.	**In-Network** $175 copay for each Medicare-covered ambulatory surgical center visit. $175 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** 30% of the cost for ambulatory surgical center benefits. 30% of the cost for outpatient hospital facility benefits.
14 – Ambulance Services (medically necessary ambulance services)	20% coinsurance.	**In-Network** $150 copay for Medicare-covered ambulance benefits. **Out-of-Network** $150 copay for ambulance benefits.	**In-Network** $150 copay for Medicare-covered ambulance benefits. **Out-of-Network** $150 copay for ambulance benefits.
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.	**General** $50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.
16 – Urgently Needed Care (This is NOT emergency care and, in most cases, is out of the service area.)	20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.	**General** $35 copay for Medicare-covered urgently needed care visits.	**General** $35 copay for Medicare-covered urgently needed care visits.

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17 – Outpatient Rehabilitation Services (occupational therapy, physical therapy, speech and language therapy)	20% coinsurance.	**In-Network** $30 copay for Medicare-covered Occupational Therapy visits. $30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. **Out-of-Network** 30% of the cost for Occupational Therapy benefits. 30% of the cost for Physical and/or Speech/ Language Therapy visits.	**In-Network** $20 copay for Medicare-covered Occupational Therapy visits. $20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. **Out-of-Network** 30% of the cost for Occupational Therapy benefits. 30% of the cost for Physical and/or Speech/ Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for durable medical equipment.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for durable medical equipment.
19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance.	**In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for prosthetic devices.	**In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for prosthetic devices.
20 – Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance.	**In-Network** $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies. Separate Office Visit cost sharing of $15 to $30 copay may apply.	**In-Network** $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies. Separate Office Visit cost sharing of $5 to $20 copay may apply.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
20 – Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (continued)	Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**Out-of-Network** 30% of the cost for Diabetes self-monitoring training. 30% of the cost for Nutrition Therapy for Diabetes. 30% of the cost for Diabetes supplies.	**Out-of-Network** 30% of the cost for Diabetes self-monitoring training. 30% of the cost for Nutrition Therapy for Diabetes. 30% of the cost for Diabetes supplies.
21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays. $0 copay for Medicare-covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	**In-Network** $30 copay for Medicare-covered lab services. $30 copay for Medicare-covered diagnostic procedures and tests. $30 copay for Medicare-covered X-rays. $175 copay for Medicare-covered diagnostic radiology services. $30 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of $15 to $30 may apply. **Out-of-Network** 30% of the cost for diagnostic procedures, tests, and lab services. 30% of the cost for therapeutic radiology services. 30% of the cost for outpatient x-rays. 30% of the cost for diagnostic radiology services.	**In-Network** $20 copay for Medicare-covered lab services. $20 copay for Medicare-covered diagnostic procedures and tests. $20 copay for Medicare-covered X-rays. $175 copay for Medicare-covered diagnostic radiology services. $20 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of $5 to $20 may apply. **Out-of-Network** 30% of the cost for diagnostic procedures, tests, and lab services. 30% of the cost for therapeutic radiology services. 30% of the cost for outpatient x-rays. 30% of the cost for diagnostic radiology services.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
PREVENTIVE SERVICES			
22 – Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**In-Network** $0 copay for Medicare-covered bone mass measurement. Separate Office Visit cost sharing of $15 to $30 may apply. **Out-of-Network** 30% of the cost for Medicare-covered bone mass measurement.	**In-Network** $0 copay for Medicare-covered bone mass measurement. Separate Office Visit cost sharing of $5 to $20 may apply. **Out-of-Network** 30% of the cost for Medicare-covered bone mass measurement.
23 – Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance. Covered when you are high risk or when you are age 50 and older.	**In-Network** $0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of $15 to $30 may apply. **Out-of-Network** 30% of the cost for colorectal screenings.	**In-Network** $0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of $5 to $20 may apply. **Out-of-Network** 30% of the cost for colorectal screenings.
24 – Immunizations (flu vaccine, hepatitis B vaccine – for people with Medicare who are at risk, pneumonia vaccine)	$0 copay for flu and pneumonia vaccines. 20% coinsurance for hepatitis B vaccine. You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information.	**In-Network** $0 copay for Flu and Pneumonia vaccines. No referral needed for Flu and pneumonia vaccines. $0 copay for Hepatitis B vaccine. Separate Office Visit cost sharing of $15 to $30 may apply. No referral needed for other immunizations. **Out-of-Network** 30% of the cost for immunizations.	**In-Network** $0 copay for Flu and Pneumonia vaccines. No referral needed for Flu and pneumonia vaccines. $0 copay for Hepatitis B vaccine. Separate Office Visit cost sharing of $5 to $20 may apply. No referral needed for other immunizations. **Out-of-Network** 30% of the cost for immunizations.
25 – Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	**In-Network** $0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of $15 to $30 may apply.	**In-Network** $0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of $5 to $20 may apply.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
25 – Mammograms (Annual Screening) (continued)		**Out-of-Network** 30% of the cost for screening mammograms.	**Out-of-Network** 30% of the cost for screening mammograms.
26 – Pap Smears and Pelvic Exams (for women with Medicare)	$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for pelvic exams.	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams. Separate Office Visit cost sharing of $15 to $30 may apply. $0 copay up to 1 additional pap smear(s) and pelvic exam(s) every year. **Out-of-Network** 30% of the cost for pap smears and pelvic exams.	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams. Separate Office Visit cost sharing of $5 to $20 may apply. $0 copay up to 1 additional pap smear(s) and pelvic exam(s) every year. **Out-of-Network** 30% of the cost for pap smears and pelvic exams.
27 – Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**In-Network** $0 copay for Medicare-covered prostate cancer screening. Separate Office Visit cost sharing of $15 to $30 may apply. **Out-of-Network** 30% of the cost for prostate cancer screening.	**In-Network** $0 copay for Medicare-covered prostate cancer screening. Separate Office Visit cost sharing of $5 to $20 may apply. **Out-of-Network** 30% of the cost for prostate cancer screening.
28 – End-Stage Renal Disease	20% coinsurance for renal dialysis. 20% coinsurance for nutrition therapy for end-stage renal disease. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** $25 copay for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease. **Out-of-Network** 30% of the cost for Nutrition Therapy for End-Stage Renal Disease. $25 copay for renal dialysis.	**In-Network** $20 copay for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease. **Out-of-Network** 30% of the cost for Nutrition Therapy for End-Stage Renal Disease. $20 copay for renal dialysis.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** $45 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs. 30% of the cost for Part B drugs out-of-network. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.aetnamedicare.com on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	**Drugs covered under Medicare Part B** **General** $45 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs. 30% of the cost for Part B drugs out-of-network. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.aetnamedicare.com on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)		Some drugs have quantity limits. Your provider must get prior authorization from Aetna Medicare Standard Plan (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a tier exception in this plan, you will pay Tier 4 - Non-Preferred Brand cost sharing. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** ***Tier 1 - Preferred Generic*** • $7 copay for a one-month (31-day) supply of drugs in this tier. • $21 copay for a three-month (90-day) supply of drugs in this tier.	Some drugs have quantity limits. Your provider must get prior authorization from Aetna Medicare Premier Plan (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a tier exception in this plan, you will pay Tier 4 - Non-Preferred Brand cost sharing. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** ***Tier 1 - Preferred Generic*** • $5 copay for a one-month (31-day) supply of drugs in this tier. • $15 copay for a three-month (90-day) supply of drugs in this tier.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)		***Tier 2 - Non-Preferred Generic*** • $25 copay for a one-month (31-day) supply of drugs in this tier. • $75 copay for a three-month (90-day) supply of drugs in this tier. ***Tier 3 - Preferred Brand*** • $30 copay for a one-month (31-day) supply of drugs in this tier. • $90 copay for a three-month (90-day) supply of drugs in this tier. ***Tier 4 - Non-Preferred Brand*** • $72 copay for a one-month (31-day) supply of drugs in this tier. • $216 copay for a three-month (90-day) supply of drugs in this tier. ***Tier 5 - Specialty*** • 25% coinsurance for a one-month (31-day) supply of drugs in this tier. • 25% coinsurance for a three-month (90-day) supply of drugs in this tier. **Long Term Care Pharmacy** ***Tier 1 - Preferred Generic*** • $7 copay for a one-month (31-day) supply of drugs in this tier. ***Tier 2 - Non-Preferred Generic*** • $25 copay for a one-month (31-day) supply of drugs in this tier. ***Tier 3 - Preferred Brand*** • $30 copay for a one-month (31-day) supply of drugs in this tier.	***Tier 2 - Non-Preferred Generic*** • $30 copay for a one-month (31-day) supply of drugs in this tier. • $90 copay for a three-month (90-day) supply of drugs in this tier. ***Tier 3 - Preferred Brand*** • $35 copay for a one-month (31-day) supply of drugs in this tier. • $105 copay for a three-month (90-day) supply of drugs in this tier. ***Tier 4 - Non-Preferred Brand*** • $80 copay for a one-month (31-day) supply of drugs in this tier. • $240 copay for a three-month (90-day) supply of drugs in this tier. ***Tier 5 - Specialty*** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier. • 33% coinsurance for a three-month (90-day) supply of drugs in this tier. **Long Term Care Pharmacy** ***Tier 1 - Preferred Generic*** • $5 copay for a one-month (31-day) supply of drugs in this tier. ***Tier 2 - Non-Preferred Generic*** • $30 copay for a one-month (31-day) supply of drugs in this tier. ***Tier 3 - Preferred Brand*** • $35 copay for a one-month (31-day) supply of drugs in this tier.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)		***Tier 4 - Non-Preferred Brand*** • $72 copay for a one-month (31-day) supply of drugs in this tier. ***Tier 5 - Specialty*** • 25% coinsurance for a one-month (31-day) supply of drugs in this tier. **Mail Order** ***Tier 1 - Preferred Generic*** • $14 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $21 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. ***Tier 2 - Non-Preferred Generic*** • $50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $75 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. ***Tier 3 - Preferred Brand*** • $60 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $90 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	***Tier 4 - Non-Preferred Brand*** • $80 copay for a one-month (31-day) supply of drugs in this tier. ***Tier 5 - Specialty*** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier. **Mail Order** ***Tier 1 - Preferred Generic*** • $10 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $15 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. ***Tier 2 - Non-Preferred Generic*** • $60 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $90 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. ***Tier 3 - Preferred Brand*** • $70 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $105 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)		***Tier 4 - Non-Preferred Brand*** • $144 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $216 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. ***Tier 5 - Specialty*** • 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. **Coverage Gap** After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	***Tier 4 - Non-Preferred Brand*** • $160 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $240 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. ***Tier 5 - Specialty*** • 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. **Coverage Gap** The plan covers many generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: **Retail Pharmacy** ***Tier 1 - Preferred Generic*** • $15 copay for a one-month (31-day) supply of all drugs covered in this tier. • $45 copay for a three-month (90-day) supply of all drugs covered in this tier. **Long Term Care Pharmacy** ***Tier 1 - Preferred Generic*** • $15 copay for a one-month (31-day) supply of all drugs covered in this tier.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)			**Mail Order** ***Tier 1 - Preferred Generic*** • $30 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail order. • $45 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail order. For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.
		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)		**Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Aetna Medicare Standard Plan (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: ***Tier 1 - Preferred Generic*** • $7 copay for a (10-day) supply of drugs in this tier. ***Tier 2 - Non-Preferred Generic*** • $25 copay for a (10-day) supply of drugs in this tier. ***Tier 3 - Preferred Brand*** • $30 copay for a (10-day) supply of drugs in this tier. ***Tier 4 - Non-Preferred Brand*** • $72 copay for a (10-day) supply of drugs in this tier.	**Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Aetna Medicare Premier Plan (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: ***Tier 1 - Preferred Generic*** • $5 copay for a (10-day) supply of drugs in this tier. ***Tier 2 - Non-Preferred Generic*** • $30 copay for a (10-day) supply of drugs in this tier. ***Tier 3 - Preferred Brand*** • $35 copay for a (10-day) supply of drugs in this tier. ***Tier 4 - Non-Preferred Brand*** • $80 copay for a (10-day) supply of drugs in this tier.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)		***Tier 5 - Specialty*** • 25% coinsurance for a (10-day) supply of drugs in this tier. **Out-of-Network Coverage Gap** After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Aetna Medicare Standard Plan (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Aetna Medicare Standard Plan (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	***Tier 5 - Specialty*** • 33% coinsurance for a (10-day) supply of drugs in this tier. **Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following: ***Tier 1 - Preferred Generic*** • $15 copay for a (10-day) supply of all drugs covered in this tier. ***Tier 2 - Non-Preferred Generic*** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Aetna Medicare Premier Plan (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Aetna Medicare Premier Plan (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)			***Tier 3 - Preferred Brand*** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Aetna Medicare Premier Plan (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Aetna Medicare Premier Plan (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. ***Tier 4 - Non-Preferred Brand*** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Aetna Medicare Premier Plan (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Aetna Medicare Premier Plan (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
29 – Prescription Drugs (continued)			***Tier 5 - Specialty*** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Aetna Medicare Premier Plan (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Aetna Medicare Premier Plan (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.
		Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A$2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.
30 – Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.") $30 copay for Medicare-covered dental benefits.	**Network** In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.") $20 copay for Medicare-covered dental benefits.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
30 – Dental Services (continued)		**Out-of-Network** 30% of the cost for comprehensive dental benefits.	**Out-of-Network** 30% of the cost for comprehensive dental benefits.
31 – Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** $0 copay for hearing aids. $30 copay for Medicare-covered diagnostic hearing exams. $0 copay for routine hearing tests. $500 limit for hearing aids every three years. **Out-of-Network** 30% of the cost for hearing exams. $0 copay for hearing aids.	**In-Network** $0 copay for hearing aids. $20 copay for Medicare-covered diagnostic hearing exams. $0 copay for routine hearing tests. $500 limit for hearing aids every three years. **Out-of-Network** 30% of the cost for hearing exams. $0 copay for hearing aids.
32 – Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for • one pair of eyeglasses or contact lenses after cataract surgery. • glasses. • contacts. $30 copay for exams to diagnose and treat diseases and conditions of the eye. $0 copay for up to 1 routine eye exam(s) every year. $100 limit for eye wear every two years. Separate Office Visit cost sharing of $15 to $30 may apply. **Out-of-Network** 30% of the cost for eye exams. $0 copay for eye wear.	**In-Network** $0 copay for • one pair of eyeglasses or contact lenses after cataract surgery. • glasses. • contacts. $20 copay for exams to diagnose and treat diseases and conditions of the eye. $0 copay for up to 1 routine eye exam(s) every year. $100 limit for eye wear every two years. Separate Office Visit cost sharing of $5 to $20 may apply. **Out-of-Network** 30% of the cost for eye exams. $0 copay for eye wear.
33 – Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
33 – Physical Exams (continued)	When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	$0 copay for Medicare-covered benefits. Separate Office Visit cost sharing of $15 to $30 may apply. **Out-of-Network** 30% of the cost for routine exams.	$0 copay for Medicare-covered benefits. Separate Office Visit cost sharing of $5 to $20 may apply. **Out-of-Network** 30% of the cost for routine exams.
34 – Health/ Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	**In-Network** The plan covers the following health/wellness education benefits: • Nutritional Training. • Additional Smoking Cessation. • Nursing Hotline. $0 copay for each Medicare-covered smoking cessation counseling session. **Out-of-Network** $0 copay for Health and Wellness services.	**In-Network** The plan covers the following health/wellness education benefits: • Nutritional Training. • Additional Smoking Cessation. • Nursing Hotline. $0 copay for each Medicare-covered smoking cessation counseling session. **Out-of-Network** $0 copay for Health and Wellness services.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.
OPTIONAL BENEFITS			
OPTIONAL SUPPLEMENTAL PACKAGE #1			
Premium and Other Important Information		**General** ***Package: 1 - Advantage Dental:*** $14 monthly premium, in addition to your $82 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services.	**General** ***Package: 1 - Advantage Dental:*** $14 monthly premium, in addition to your $143 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services.
Dental Services		**In-Network** • up to 2 oral exam(s) every year. • dental x-rays.	**In-Network** • up to 2 oral exam(s) every two years. • dental x-rays.

Benefit Category	Original Medicare	Aetna Medicare Standard Plan (PPO)	Aetna Medicare Premier Plan (PPO)
Dental Services (continued)		$5 copay for an office visit that includes: • up to 2 cleaning(s) every year. **Out-of-Network** 50% of the cost for preventive dental services. 50% of the cost for comprehensive dental services.	$5 copay for an office visit that includes: • up to 2 cleaning(s) every two years. **Out-of-Network** 50% of the cost for preventive dental services. 50% of the cost for comprehensive dental services.

Health insurance plans are offered by Aetna Health Inc., Aetna Health of California Inc. and/or Aetna Life Insurance Company. Coverage is provided through a Medicare Advantage organization with a Medicare contract. Benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

Higher costs apply for out-of-network services. The plan provides reimbursement for all covered benefits regardless of whether they are received in-network, as long as they are medically necessary. Precertification, or prior approval of coverage, is requested for certain services. Providers must be licensed and eligible to receive payment under the federal Medicare program.

Medicare beneficiaries may enroll in a plan only during specific times of the year. To obtain additional information, please contact Member Services at 1-800-832-2640 (TTY/TDD 1-888-760-4748).

Translation of this material into another language may be available. For assistance, please call Member Services at 1-800-282-5366 (TTY/TDD: 1-888-760-4748). Puede estar disponible la traducción de este material en otro idioma. Para ayuda, por favor llame a Servicios al Miembro al 1-800-282-5366 (TTY/TDD: 1-888-760-4748).

This material is for informational purposes only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy clinical programs such as precertification, step therapy, and quantity limits may apply to your prescription drug coverage.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are not insured benefits.

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