



# 2023 Plan Guide

## CAPITAL-HUDSONVALLEY

Below are in-network costs for some of our Medicare benefits. It's not a complete list. For more information about these plans, refer to the Summary of Benefits, visit our website [AetnaMedicare.com](https://www.aetna.com/medicare) or call us at **1-833-859-6031 (TTY: 711)**. Your call may be answered by a licensed agent.

Benefits listed are for services received in-network and per visit unless otherwise stated	Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0	Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0	Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0	Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0	Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23	Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37	Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0
Service area	NY-Albany, Columbia, Delaware, Dutchess, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington	NY-Albany, Columbia, Delaware, Dutchess, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington	NY-Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates	NY-Albany, Columbia, Delaware, Dutchess, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington	NY-Albany, Columbia, Delaware, Dutchess, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington	NY-Albany, Columbia, Delaware, Dutchess, Greene, Montgomery, Orange, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington	NY-Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates
Part B premium reduction	\$0	\$0	\$45	\$0	\$0	\$0	\$55
Plan deductible	\$0	\$0	\$0	\$1,000* for certain in-network and out-of-network services combined.	\$0	\$0	\$0

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Annual maximum out-of-pocket amount (does not include premium or prescription drugs)	\$7,550 for in-network services.	\$7,550 for in-network services. \$11,300 for in- and out-of-network services combined.	\$7,550 for in-network services. \$11,300 for in- and out-of-network services combined.	\$7,550 for in-network services. \$11,300 for in- and out-of-network services combined.	\$7,550 for in-network services. \$11,300 for in- and out-of-network services combined.	\$7,550 for in-network services. \$11,300 for in- and out-of-network services combined.	\$7,000 for in-network services. \$9,500 for in- and out-of-network services combined.
<b>* Deductible will apply to the following in-network services: Inpatient hospital, inpatient psychiatric, skilled nursing facility, therapeutic radiology, outpatient hospital services (including observation), ambulatory surgery center (ASC) and dialysis. See the Evidence of Coverage for details.</b>							
<b>Hospital coverage</b>							
Inpatient hospital care	\$335 per day, days 1-6; \$0 per day, days 7-90 \$0 copay for additional days. Plan covers unlimited hospital days.	\$335 per day, days 1-6; \$0 per day, days 7-90 \$0 copay for additional days. Plan covers unlimited hospital days.	\$395 per day, days 1-5; \$0 per day, days 6-90 \$0 copay for additional days. Plan covers unlimited hospital days.	\$750 per stay after plan deductible Plan covers unlimited hospital days.	\$325 per day, days 1-6; \$0 per day, days 7-90 \$0 copay for additional days. Plan covers unlimited hospital days.	\$390 per day, days 1-5; \$0 per day, days 6-90 \$0 copay for additional days. Plan covers unlimited hospital days.	\$350 per day, days 1-5; \$0 per day, days 6-90 \$0 copay for additional days. Plan covers unlimited hospital days.
Outpatient hospital	\$40 - \$395 Lower cost sharing is for outpatient hospital services other than surgery.	\$35 - \$325 Lower cost sharing is for outpatient hospital services other than surgery.	\$45 - \$395 Lower cost sharing is for outpatient hospital services other than surgery.	\$40 - \$350 after plan deductible Lower cost sharing is for outpatient hospital services other than surgery.	\$35 - \$350 Lower cost sharing is for outpatient hospital services other than surgery.	\$40 - \$350 Lower cost sharing is for outpatient hospital services other than surgery.	\$35 - \$350 Lower cost sharing is for outpatient hospital services other than surgery.
Ambulatory surgery center (ASC)	\$175	\$200	\$250	\$175 after plan deductible	\$175	\$175	\$175
Skilled nursing facility	\$0 per day, days 1-20; \$196 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$196 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$196 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$196 per day, days 21-100 after plan deductible Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$196 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$196 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$196 per day, days 21-100 Our plan covers up to 100 days per benefit period.
<b>Doctor visits</b>							
Primary care physician (PCP)	\$5	\$0	\$10	\$0	\$0	\$0	\$0
PCP referrals	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.
Specialist	\$40	\$35	\$45	\$40	\$35	\$40	\$35
<b>Emergency and urgent care</b>							
Emergency care	\$95	\$95	\$95	\$95	\$95	\$95	\$95
Urgently needed services	\$50	\$50	\$50	\$50	\$50	\$50	\$50

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Worldwide coverage (i.e., outside of the United States)	\$95 for emergency and urgent services worldwide.	\$95 for emergency and urgent services worldwide.	\$95 for emergency and urgent services worldwide.	\$95 for emergency and urgent services worldwide.	\$95 for emergency and urgent services worldwide.	\$95 for emergency and urgent services worldwide.	\$95 for emergency and urgent services worldwide.
<b>Diagnostic testing</b>							
X-rays and diagnostic radiology (e.g., CT Scan, MRI)	X-rays: \$40 Diagnostic radiology: \$175 - \$250 Lower cost sharing is for CT/CAT scans.	X-rays: \$35 Diagnostic radiology: \$200 - \$300 Lower cost sharing is for CT/CAT scans.	X-rays: \$45 Diagnostic radiology: \$300 - \$350 Lower cost sharing is for CT/CAT scans.	X-rays: \$40 Diagnostic radiology: \$200 - \$275 Lower cost sharing is for CT/CAT scans.	X-rays: \$35 Diagnostic radiology: \$225 - \$300 Lower cost sharing is for CT/CAT scans.	X-rays: \$40 Diagnostic radiology: \$175 - \$250 Lower cost sharing is for CT/CAT scans.	X-rays: \$35 Diagnostic radiology: \$200 - \$300 Lower cost sharing is for CT/CAT scans.
Lab services	\$0	\$0	\$5 You'll pay \$0 for certain lab services.	\$0	\$0	\$0	\$0
<b>Dental, vision and hearing (non-Medicare covered)</b>							
Dental services	\$1,000 maximum benefit in- and out-of-network every year for preventive and comprehensive dental combined.  Aetna Dental PPO Network	\$1,000 maximum benefit in- and out-of-network every year for preventive and comprehensive dental combined.  Aetna Dental PPO Network	See optional supplemental benefits below.	\$1,500 maximum benefit in- and out-of-network every year for preventive and comprehensive dental combined.  Aetna Dental PPO Network	\$1,000 maximum benefit in- and out-of-network every year for preventive and comprehensive dental combined.  Aetna Dental PPO Network	\$1,000 reimbursement** every year for preventive and comprehensive dental combined.  You can see any licensed U.S. provider.	\$2,000 maximum benefit in- and out-of-network every year for preventive and comprehensive dental combined.  Aetna Dental PPO Network
Routine eye exam	\$0 (one exam every year)	\$0 (one exam every year)	\$0 (one exam every year)	\$0 (one exam every year)	\$0 (one exam every year)	\$0 (one exam every year)	\$0 (one exam every year)
Eyewear	\$250 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.	\$200 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.	\$150 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.	\$200 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.	\$150 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.	\$200 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.	\$250 reimbursement** every year.  You can see any licensed U.S. provider. Discounts may be available when seeing an EyeMed provider.
Routine hearing exam	\$0 (one exam every year)  All appointments must be scheduled through NationsHearing.	\$0 (one exam every year)  All appointments should be scheduled through NationsHearing.	\$0 (one exam every year)  All appointments should be scheduled through NationsHearing.	\$0 (one exam every year)  All appointments should be scheduled through NationsHearing.	\$0 (one exam every year)  All appointments should be scheduled through NationsHearing.	\$0 (one exam every year)  All appointments should be scheduled through NationsHearing.	\$0 (one exam every year)  All appointments should be scheduled through NationsHearing.

Benefits listed are for services received in-network and per visit unless otherwise stated	Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0	Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0	Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0	Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0	Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23	Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37	Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0
Hearing aids	\$0 copay with a \$1,000 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.	\$0 copay with a \$1,000 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.	\$0 copay with a \$750 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.	\$0 copay with a \$1,250 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.	\$0 copay with a \$1,000 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.	\$0 copay with a \$1,250 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.	\$0 copay with a \$1,250 (per ear) maximum benefit every year.  All hearing aids must be purchased through NationsHearing.
<b>**Member pays the provider upfront and we pay the member back. Plan coverage rules apply.</b>							
<b>Therapy</b>							
Physical and speech therapy	\$40	\$35	\$40	\$40	\$40	\$40	\$40
Occupational therapy	\$40	\$35	\$40	\$40	\$40	\$40	\$40
Outpatient mental health therapy (individual)	\$40	\$35	\$40	\$40	\$40	\$40	\$40
<b>Ambulance</b>							
Ground ambulance (one-way trip)	\$300	\$300	\$290	\$300	\$295	\$300	\$300
Air ambulance (one-way trip)	\$300	\$300	\$300	\$300	\$300	\$300	\$300
<b>Equipment and prosthetics</b>							
Durable medical equipment	0% - 20% Lower cost sharing is for continuous glucose meters.	0% - 20% Lower cost sharing is for continuous glucose meters.	0% - 20% Lower cost sharing is for continuous glucose meters.	0% - 20% Lower cost sharing is for continuous glucose meters.	0% - 20% Lower cost sharing is for continuous glucose meters.	0% - 20% Lower cost sharing is for continuous glucose meters.	0% - 20% Lower cost sharing is for continuous glucose meters.
Prosthetics	20%	20%	20%	20%	20%	20%	20%



<b>Additional benefits</b>	<b>Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0</b>	<b>Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0</b>	<b>Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0</b>	<b>Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0</b>	<b>Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23</b>	<b>Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37</b>	<b>Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0</b>
24-Hour Nurse Line	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	\$0 Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.
Extra Benefits	Members with six or more chronic conditions who meet certain criteria may be eligible for: • \$0 copay for Primary Care Physician (PCP) and telehealth services when using Landmark providers  See the Evidence of Coverage for more information	Not covered	Members with six or more chronic conditions who meet certain criteria may be eligible for: • \$0 copay for Primary Care Physician (PCP) and telehealth services when using Landmark providers  See the Evidence of Coverage for more information	Not covered	Not covered	Not covered	Not covered
Fitness	Physical fitness program: Basic membership at participating SilverSneakers® facilities.	Physical fitness program: Basic membership at participating SilverSneakers® facilities.	Physical fitness program: Basic membership at participating SilverSneakers® facilities.	Physical fitness program: Basic membership at participating SilverSneakers® facilities.	Physical fitness program: Basic membership at participating SilverSneakers® facilities.	Physical fitness program: Basic membership at participating SilverSneakers® facilities.	Physical fitness program: Basic membership at participating SilverSneakers® facilities.
Meals	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility to home.
Over-the-counter items (OTC)	Not covered	Not covered	Not covered	Not covered	\$60 quarterly to be used towards items from our OTC catalog such as pain relievers, cold remedies and vitamins.	Not covered	\$45 quarterly to be used towards items from our OTC catalog such as pain relievers, cold remedies and vitamins.

Additional benefits	Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0	Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0	Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0	Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0	Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23	Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37	Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0
Visitor/travel benefit	Travel Advantage program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.	Explorer program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.	Explorer program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.	Explorer program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.	Explorer program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.	Explorer program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.	Explorer program: Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to twelve months when outside the service area.

Optional Supplemental Benefits (extra benefits you can purchase)	Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0	Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0	Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0	Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0	Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23	Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37	Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0
Option 1 (Beyond Original Medicare coverage)	Not applicable	Not applicable	\$15 monthly premium Deluxe Dental Package	Not applicable	Not applicable	Not applicable	Not applicable
Optional Supplemental Benefits Description(s)	Not applicable	Not applicable	Dental Network: Aetna Dental® PPO Network  \$1,000 dental benefit maximum every year for preventive and comprehensive services combined.	Not applicable	Not applicable	Not applicable	Not applicable

Prescription drugs (Retail/Mail Pharmacy)	Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0	Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0	Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0	Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0	Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23	Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37	Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0
Rx deductible	\$300  Does not apply to Tier 1, Tier 2 drugs.	\$250  Does not apply to Tier 1, Tier 2 drugs.	\$350  Does not apply to Tier 1, Tier 2 drugs.	\$195  Does not apply to Tier 1, Tier 2 drugs.	\$250  Does not apply to Tier 1, Tier 2 drugs.	\$195  Does not apply to Tier 1, Tier 2 drugs.	No Part D benefit Cannot add a Part D plan
Tier 1 Drugs: • Retail: 30-day supply • Retail/Mail: 100-day supply	Preferred/Standard  \$0 / \$15 \$0 / \$45	Preferred/Standard  \$0 / \$15 \$0 / \$45	Preferred/Standard  \$0 / \$15 \$0 / \$45	Preferred/Standard  \$0 / \$15 \$0 / \$45	Preferred/Standard  \$0 / \$15 \$0 / \$45	Preferred/Standard  \$0 / \$15 \$0 / \$45	No Part D benefit Cannot add a Part D plan

Prescription drugs (Retail/Mail Pharmacy)	Aetna Medicare Value Plan (HMO-POS) H3312-062 Monthly Plan Premium: \$0	Aetna Medicare Premier Plus Plan (PPO) H5521-382 Monthly Plan Premium: \$0	Aetna Medicare Credit Plan (PPO) H5521-313 Monthly Plan Premium: \$0	Aetna Medicare Elite Plan (PPO) H5521-119 Monthly Plan Premium: \$0	Aetna Medicare Discover Value Plan (PPO) H5521-383 Monthly Plan Premium: \$23	Aetna Medicare Premier Plan (PPO) H5521-110 Monthly Plan Premium: \$37	Aetna Medicare Eagle Plan (PPO) H5521-323 Monthly Plan Premium: \$0
Tier 2 Drugs: • Retail: 30-day supply • Retail/Mail: 100-day supply	Preferred/Standard \$10 / \$20 \$20 / \$60	Preferred/Standard \$10 / \$20 \$20 / \$60	Preferred/Standard \$10 / \$20 \$20 / \$60	Preferred/Standard \$0 / \$20 \$0 / \$60	Preferred/Standard \$10 / \$20 \$20 / \$60	Preferred/Standard \$0 / \$20 \$0 / \$60	No Part D benefit Cannot add a Part D plan
Tier 3 Drugs: • Retail: 30-day supply • Retail/Mail: 100-day supply	Preferred/Standard \$47 / \$47 \$141 / \$141	Preferred/Standard \$47 / \$47 \$141 / \$141	Preferred/Standard \$47 / \$47 \$141 / \$141	Preferred/Standard \$47 / \$47 \$141 / \$141	Preferred/Standard \$47 / \$47 \$141 / \$141	Preferred/Standard \$47 / \$47 \$141 / \$141	No Part D benefit Cannot add a Part D plan
Tier 4 Drugs: • Retail: 30-day supply • Retail/Mail: 100-day supply	Preferred/Standard \$100 / \$100 \$300 / \$300	Preferred/Standard \$100 / \$100 \$300 / \$300	Preferred/Standard \$100 / \$100 \$300 / \$300	Preferred/Standard \$100 / \$100 \$300 / \$300	Preferred/Standard \$100 / \$100 \$300 / \$300	Preferred/Standard \$100 / \$100 \$300 / \$300	No Part D benefit Cannot add a Part D plan
Tier 5 Drugs: • Retail: 30-day supply • Retail/Mail: 100-day supply	Preferred/Standard 28% / 28% N/A	Preferred/Standard 29% / 29% N/A	Preferred/Standard 27% / 27% N/A	Preferred/Standard 30% / 30% N/A	Preferred/Standard 29% / 29% N/A	Preferred/Standard 30% / 30% N/A	No Part D benefit Cannot add a Part D plan
Gap coverage	Yes, Tier 1 & 2	Yes, Tier 1 & 2	Yes, Tier 1 & 2	Yes, Tier 1 & 2	Yes, Tier 1 & 2	Yes, Tier 1 & 2	No Part D benefit Cannot add a Part D plan

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

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

Aetna Medicare's pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri and Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower cost preferred pharmacies in your area, please call 1-833-859-6031 (TTY: 711) or consult the online pharmacy directory at [AetnaMedicare.com/findpharmacy](https://www.aetnamedicare.com/findpharmacy).

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health family of companies.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-833-810-6150 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-810-6150 (TTY: 711).

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