Summary of Benefits 2027

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Sponsored by Aetna Medicare Plan (PPO)
Medicare (P01) ESA PPO, Rx $10/$20/$40

Important Information

This is a summary of the services we cover from January 1, 2027 through December 31, 2027. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). To request a copy, contact:

Member Services
1-888-267-2637 (**TTY:** 711) Hours are 8 AM to 9 PM ET, Monday through Friday.

Are you eligible to enroll?

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

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area. A complete list of service areas can be found in the *Evidence of Coverage* (EOC).



What You Should Know

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

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

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

Plan costs & information	Network & Out-of-network providers
Premium	Please contact your former employer/union/ trust for more information on your plan premium.
Annual Deductible	$0
	This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.
Annual Maximum Out-of-Pocket	$1,000
	The maximum out-of-pocket (MOOP) is the **most you'll pay** for the medical services we cover each year. **It's in place to protect you**. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.

PRIMARY BENEFITS	Your costs for in and out-of-network care
Hospital Care*	
Inpatient Hospital Care	$0 per stay The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Observation Stay	Your cost share for Observation Care is based upon the services you receive. Frequency: per stay
Outpatient Hospital Services and Surgery	$0
Ambulatory Surgery Center	$0
Primary Care Provider and Specialist Services	
Primary Care Provider Visits	$10 Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.
Specialist Visits	$15
Preventive Services	
Medicare-covered Preventive Services • Abdominal aortic aneurysm screenings • Alcohol misuse screenings and counseling • Annual Wellness visit • Bone mass measurements • Breast cancer screening: mammogram • Cardiovascular behavioral therapy • Cardiovascular disease screenings • Cervical and vaginal cancer screenings • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screenings • Diabetes screenings • HIV screenings • Lung cancer screenings and counseling • Medicare Diabetes Prevention Program • Medical nutrition therapy	$0

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PRIMARY BENEFITS	Your costs for in and out-of-network care
Preventive Services (continued)	
• Obesity therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit	
Immunizations • Flu/Influenza • Hepatitis B • Pneumonia	$0
Additional Medicare Preventive Services • Diabetes self-management training • Digital rectal exam • EKG following welcome exam • Glaucoma screening	$0
Emergency and Urgent Medical Care	
Emergency Care	$50 (waived if admitted immediately)
Emergency Care Worldwide	$50 (waived if admitted)
Urgent Care	$15
Urgent Care Worldwide	$15
Diagnostic Procedures*	
Diagnostic Radiology (CT scans)	$15
Diagnostic Radiology (other than CT scans)	$15
Diagnostic Testing and Procedures	$15
Lab Services	$15
Outpatient X-rays	$15
Hearing Services	
Hearing Exam (routine)	$0 Coverage: 1 exam every 12 months
Hearing Exam (Medicare-covered)	$15
Dental Services*	

PRIMARY BENEFITS	Your costs for in and out-of-network care
Dental Services	$15
	Medicare-covered benefits only
Vision Services	
Eye Exam (routine)	$0
	Coverage: one exam every year
Diabetic Eye Exam	$0
Eye Exam (Medicare-covered)	$15
Eyewear Reimbursement	$100 once every 24 months
Mental Health Services*	
Inpatient Mental Health Care	$0 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Mental Health Care	$15 (individual sessions)
	$15 (group sessions)
Partial Hospitalization Services	$15
Intensive Outpatient Service	$15
Inpatient Substance Use Disorder	$0 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Substance Use Disorder	$15 (individual sessions)
	$15 (group sessions)
Skilled Nursing Services*	
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $75 per day, days 21-100
	Limited to 100 days per Medicare benefit period. See the *Schedule of Cost Sharing* for details on the benefit periods.
Outpatient Rehabilitation Services	
Occupational Therapy Rehabilitation Services	$15
Physical and Speech Therapy Rehabilitation Services	$15
Ambulance* and Transportation Services	

PRIMARY BENEFITS	Your costs for in and out-of-network care
Ambulance Services	$15
	Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.
Transportation (non-emergency)	Covered
	Coverage: up to 24 one-way trips per year with 60 miles allowed per trip. Services should be scheduled through our authorized vendor, MTM Health.
Worldwide Emergency Transportation (non-Medicare covered)	$15
Medicare Part B Prescription Drugs*	
Medicare Part B Prescription Drugs	$0
Medicare Part B Prescription Drugs - Insulin	$0

***These benefits may require prior authorization.**

Medicare Part D Prescription Drugs

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section on page 10 for your plan benefits at each Part D phase, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in and out-of-network care
Acupuncture Services	$15 Medicare-covered benefits only
Allergy Shots	$0
Allergy Testing	$15
Blood	$0 All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	$15
Chiropractic Services*	$15 Medicare-covered benefits only
Continuous Glucose Monitor	$0
Continuous Glucose Supplies	$0
Diabetic Supplies*	$0 Includes supplies to monitor your blood glucose from Accu-Chek/ Roche and TRUE/Trividia, or from a non-preferred provider when a prior authorization is received.
Durable Medical Equipment (DME)*	15%
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.
Intensive Cardiac Rehabilitation Services	$15
Medical Supplies*	Your cost share is based upon the provider of services
Outpatient Dialysis Treatments*	$15
Podiatry Services	$15 Medicare-covered benefits only
Prosthetic Devices*	15%
Pulmonary Rehabilitation Services	$15
Supervised Exercise Therapy (SET) for PAD	$15
Radiation Therapy*	$15

***These benefits may require prior authorization.**

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Basic SilverSneakers® Program	You are covered for a basic membership to any SilverSneakers® authorized participating fitness facility. Additionally, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers.
Meals	$0 After discharge from an inpatient stay to your home, you may be eligible to receive up to 14 home-delivered meals over a 7-day period.
Resources for Living®	This program is offered to help you locate resources for everyday needs.
Routine Physical	$0
	A routine physical exam is offered once per calendar year.
Smoking and Tobacco Use Cessation Supplies	$0
Frequency	unlimited visits every year
Teladoc™	$0
	Telemedicine services with a Teladoc provider. State mandates may apply.
Telehealth PCP	$10
Telehealth Specialist	$15
Telehealth Occupational Therapy Service	$15
Telehealth PT and ST Services	$15
Telehealth Other Health Care Providers	$15
Telehealth Individual Mental Health*	$15
Telehealth Group Mental Health*	$15
Telehealth Individual Psychiatric Services*	$15
Telehealth Group Psychiatric Services*	$15
Telehealth Individual Outpatient Substance Use Disorder*	$15
Telehealth Group Outpatient Substance Use Disorder*	$15
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services*	$15
Telehealth Urgent Care	$15
Wigs	$0

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Maximum	$400
Frequency	every year
***These benefits may require prior authorization.**	

PHARMACY - PRESCRIPTION DRUG BENEFITS

Deductible	**$0**
Pharmacy Network	**S2**

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

Formulary (Drug List)	**Comprehensive Plus**

INITIAL COVERAGE PHASE

This is your cost sharing until covered Medicare prescription drug expenses reach the $2,400 annual out-of-pocket limit:

	30-day Supply through Network Retail	90-day Supply through Network Retail or Mail	
3 Tier plan	**Standard**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 Generic drugs	You pay $10	You pay $20	You pay $20
Tier 2 Preferred Brand drugs	You pay $20	You pay $40	You pay $40
Tier 3 Non-Preferred Brand drugs	You pay $40	You pay $80	You pay $80

You won't pay more than $35 for a one-month supply or $105 for up to a 90-day supply of each covered insulin product regardless of the cost-sharing tier.

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

CATASTROPHIC COVERAGE PHASE

Catastrophic Coverage benefits start once the annual out-of-pocket threshold of $2,400 for covered Part D prescription drugs is reached. Once you are in the Catastrophic Coverage Phase, you will stay in this payment phase until the end of the calendar year.

- During this payment phase, you pay nothing for your covered Part D drugs.
- You may have cost sharing for drugs that are covered under our Non-Part D Supplemental Benefit

REQUIREMENTS

Precertification	Applies

Step Therapy	Does Not Apply

NON-PART D SUPPLEMENTAL BENEFIT

- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents when used for anorexia, weight loss, or weight gain
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Select prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Other miscellaneous non-Part D drugs not otherwise described above

MEDICAL DISCLAIMERS

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

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

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

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

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

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

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

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

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

PHARMACY DISCLAIMERS

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

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

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30-day supply.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

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

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

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

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

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

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

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

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

PLAN DISCLAIMERS

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

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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

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.

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

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

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

You can read the *Medicare & You 2027* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**www.medicare.gov**) or by calling 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

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

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Notice of Availability (NOA)

TTY: 711

To access language assistance services and appropriate auxiliary aids and services at no cost to you, call the number on this document. (English)

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للوصول إلى خدمات المساعدة اللغوية والمساعدات والخدمات المساندِة المناسبة دون أي تكلفة عليك، اتصل بالرقم الوارد في هذا المستند. (Arabic)

如欲獲得免費的語言輔助服務以及適當的輔助工具和服務，請撥打本文件上的電話號碼。 (Chinese)

Pou w jwenn aksè ak sèvis sipò lang gratis ansanm ak sèvis asistans ak sipò apwopriye, tanpri rele nimewo ki endike sou dokiman sa a. (French Creole)

Pour accéder aux services d'assistance linguistique et aux aides et services auxiliaires appropriés sans frais à votre charge, appelez le numéro indiqué dans ce document. (French)

Um Sprachunterstützung sowie geeignete Hilfsmittel und Dienstleistungen kostenlos in Anspruch zu nehmen, rufen Sie bitte die auf diesem Dokument angegebene Nummer an. (German)

તમારા માટે વિના મૂલ્યે ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો તથા સેવાઓ મેળવવા માટે, આ દસ્તાવેજ પર આપેલા નંબર પર કૉલ કરો. (Gujarati)

No ke komo ʻana i nā lawelawe kōkua ʻōlelo a me nā mea kōkua kūpono a me nā lawelawe me ka uku ʻole iā ʻoe, e kelepona i ka helu ma kēia palapala. (Hawaiian)

Kom siv tau cov kev pab cuam txhais lus thiab cov khoom pab kom hnov lus thiab cov kev pab cuam yam tsis sau nqi ntawm koj, hu tus npawb xov tooj ntawm daim ntawv thov no. (Hmong)

Contattare il numero nel presente documento per accedere, senza costi aggiuntivi, ai servizi di assistenza linguistica e ad idonei aiuti ausiliari. (Italian)

言語支援サービスや適切な補助具やサービスを無料で利用するには、こちらの文書の電話番号までお電話ください。 (Japanese)

လၢတၢ်ကမၤနှံသူကိုဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်ဒီးတၢ်မၤစၢၤလၢအကဲထိဉ်သ့လၢအဖိးမံတဖဉ်ဒီးတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတလိဉ်နဟ့ဉ်အပှၤအဂီၢ်နှဉ်,ကိးဘဉ်နီၢ်ဂံၢ်လၢလံာ်တဘ့ဉ်အံၤအလိၤတက့ၢ်. (Karen)

ដើម្បីទទួលបានសេវាកម្មជំនួយផ្នែកភាសា និងការគាំទ្រ និងសេវាកម្មបន្ថែមសមស្របដោយមិនគិតថ្លៃ សម្រាប់អ្នក សូមទូរសព្ទទៅលេខនៅលើឯកសារនេះ។ (Khmer)

언어 지원 서비스와 적절한 보조 지원 및 서비스를 무료로 이용하려면 본 문서에 나와 있는 번호로 전화해 주시기 바랍니다. (Korean)

ເພື່ອເຂົ້າເຖິງການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ອຸປະກອນຊ່ວຍໃນການຟັງ ແລະ ການບໍລິການອື່ນໆ ໂດຍທ່ານບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, ໃຫ້ໂທຫາເບີໃນເອກະສານນີ້. (Lao)

Tajaajilawwan gargaarsa afaanii fi tajaajilawwan gargaarsaa dabalataa mijaawaa ta'an kaffaltii tokko malee argachuuf, lakkoofsa sanada kana irra jirutti bilbilaa. (Oromo)

(Persian) برای دسترسی رایگان به خدمات کمک زبانی و وسایل و خدمات کمکی مناسب، با شماره درجشده در این سند تماس بگیرید.

Aby skorzystać z usług pomocy językowej oraz odpowiednich środków pomocniczych i usług bez ponoszenia żadnych kosztów, zadzwoń pod numer podany w niniejszym dokumencie. (Polish)

Para aceder, sem custos para si, a serviços de assistência linguística e a auxílios e serviços de apoio adequados, ligue para o número indicado neste documento. (Portuguese)

Чтобы бесплатно воспользоваться услугами языковой поддержки, а также соответствующими вспомогательными средствами и услугами, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para tener acceso a los servicios de asistencia en otros idiomas y a las ayudas y servicios auxiliares adecuados sin costo para usted, llame al número que figura en este documento. (Spanish)

Upang ma-access ang mga serbisyo sa tulong sa wika at mga angkop na pantulong na kagamitan at serbisyo nang hindi ka gagastos, tawagan ang numero sa dokumentong ito. (Tagalog)

หากต้องการเข้าถึงบริการช่วยเหลือด้านภาษาและอุปกรณ์ช่วยเหลืออื่น ๆ ทีเหมาะสมโดยไม่เสียค่าใช้จ่าย โปรดติดต่อหมายเลขทีระบุในเอกสารนี (Thai)

Để tiếp cận các dịch vụ hỗ trợ ngôn ngữ, công cụ hỗ trợ và dịch vụ phụ trợ phù hợp miễn phí dành cho quý vị, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)