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Schedule of Benefits

Medicare Enhance
MASSACHUSETTS

This Schedule of Benefits summarizes your coverage under Medicare Enhance ("the Plan") and states the Subscriber cost-sharing amounts that you must pay for Covered Services. However, it is only a summary of your benefits. Please see your *Benefit Handbook* for detailed information on the benefits covered by the Plan and the terms and conditions of coverage.

Please note that the information on Medicare benefits in this document is provided for informational purposes only. HPHC Insurance Company, Inc. (HPIC) is not responsible for Medicare benefits. Please refer to the Medicare handbook *Medicare & You* or contact the Centers for Medicare and Medicaid Services (CMS) at **1-800-MEDICARE (1-800-633-4227)** or **www.medicare.gov** for information on your Medicare benefits.

Section 1: Subscriber Cost Sharing (What You Pay)

Subscribers are required to share the cost of the benefits provided under the Plan. Please see the tables below for a detailed list of the cost sharing that applies to your Employer Group's plan.

A Copayment is a dollar amount that is payable by the Subscriber for certain Covered Services. The Copayment is due at the time services are rendered or when billed by the Provider. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

Payment Maximum: The Plan pays up to the Payment Maximum. You pay any charges above the Payment Maximum, plus any Subscriber cost-sharing amounts that apply under your Plan. If your Plan provides coverage for a service that is not covered by Medicare, the Plan will pay all charges up to the Payment Maximum minus the applicable cost sharing.

Section 2: Preventive Care Services

Medicare covers a number of preventive care services at no cost to Subscribers. The Plan will pay the Medicare Deductible and Coinsurance amounts, if any, for Medicare-covered preventive care services.

Medicare coverage includes a one-time "Welcome to Medicare" preventive visit received within the first 12 months a beneficiary is covered by Medicare Part B. HPIC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly "Wellness" visit. Your first yearly "Wellness" visit must occur 12 months after your Part B enrollment or your "Welcome to Medicare" preventive visit.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings; (5) Bone mass measurements; (6) Glaucoma tests; (7) Medical nutrition therapy services; (8) Counseling to prevent tobacco use & tobacco-caused disease; (9) Colorectal cancer screenings, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema; and (10) Immunizations for flu, pneumococcal shots and hepatitis B shots.

The Plan will also provide coverage, less any payments by Medicare, for the following preventive care services: annual routine physical exams, annual routine eye exams, and annual routine hearing exams. Please refer to Section III.D.2. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan.

Section 3: Emergency Coverage Outside of the United States

Your Plan provides limited emergency coverage for Subscribers traveling outside of the United States. Please refer to Section III.D.3. of your Benefit Handbook for details of your coverage.

Section 4: Inpatient Services Covered by Medicare

Benefit Period: The way that Original Medicare measures a Subscriber's use of Hospital and Skilled Nursing Facility services. A Medicare Benefit Period begins the first day of a Medicare-covered stay at an inpatient Hospital or Skilled Nursing Facility. It ends when you have not received any inpatient Hospital care or Skilled Nursing Facility care for 60 days in a row. If you go into a Hospital or a Skilled Nursing Facility after one Benefit Period has ended, a new Benefit Period begins. Medicare puts no limit on the number of Benefit Periods covered by Medicare during your lifetime.

Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Hospital Care (including acute, nonmedical health care institutions, psychiatric and rehabilitation hospitalization)			
First 60 days of a Benefit Period	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$50 Inpatient Hospital Copayment per admission per quarter
61st through 90th day of a Benefit Period	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$50 Inpatient Hospital Copayment per admission per quarter
91st day and after of a Benefit Period – up to 60 Lifetime Reserve Days (if any)	Covered less Lifetime Reserve Days Daily Coinsurance	Medicare Lifetime Reserve Days Daily Coinsurance	$50 Inpatient Hospital Copayment per admission per quarter
Non-Medicare Covered Services			
After your 60 Lifetime Reserve Days are exhausted, your plan covers unlimited days	Nothing	All charges	$50 Inpatient Hospital Copayment per admission per quarter
Skilled Nursing Facility Care (SNF)			
First 20 days of a Benefit Period	Medicare allowable amount	Nothing	No charge

Medicare Inpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Skilled Nursing Facility Care (SNF) (Continued)			
21st through 100th day of a Benefit Period	Medicare allowable amount minus SNF Daily Coinsurance	The Medicare SNF Daily Coinsurance	$50 Inpatient Hospital Copayment per admission per quarter
101st day and after of a Benefit Period	Nothing	Nothing	All charges
Physicians and Other Health Professionals (inpatient services)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Blood Transfusions			
First three pints per calendar year	Nothing	Medicare Blood Deductible	No charge
Beyond 3 pints per calendar year	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge

Section 5: Outpatient Services Covered by Medicare

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Acupuncture Treatment			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Administration of Allergy Injections			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$5 Copayment per visit
Ambulance Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Cardiac Rehabilitation Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Chiropractic Services			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Dental Care and Oral Surgery			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Diagnostic Tests and Procedures			
Diagnostic tests and procedures	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Durable Medical Equipment (DME) and Prosthetic Devices			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Emergency Room Care			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$50 Emergency Room Copayment per visit, waived if admitted to a Hospital
Home Health Care			
	Medicare allowable amount	Nothing	No charge
Home Infusion Therapy			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Hospice Care (including inpatient Respite Care)			
Additional Hospice benefits may apply. See "Section 6: State Mandated Benefits" below.	100% of the Medicare allowable amount; and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance) Benefits are covered less Medicare Deductible	Medicare Deductible and Hospice Coinsurance	No charge

Medicare Outpatient Services	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
House Calls			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$25 Copayment per visit
Kidney Dialysis			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Medical Therapies			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Outpatient Surgery			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	No charge
Physical, Occupational and Speech Therapy			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Physicians and Other Health Professionals (including mental health and substance use disorder treatment)			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Podiatrist Services			
Note: Limited coverage provided by Medicare. See your Benefit Handbook for details.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Telemedicine Virtual Visits			
Additional Telemedicine Virtual Visits benefits may apply. See "Section 6: State Mandated Benefits" below.	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit
Urgent Care Services			
	Covered less Medicare Deductible and Coinsurance	Medicare Deductible and Coinsurance	$15 Copayment per visit

Section 6: ADDITIONAL COVERED SERVICES

The plan will cover the benefits in this section when Medicare coverage is not available:

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Applied Behavioral Analysis			
	Nothing	All charges less applicable cost sharing	$15 Copayment per visit
COVID-19			
– Testing, treatment, and vaccines See your Benefit Handbook for details.	Nothing	All charges	No charge
Emergency Services received outside of the United States			
Note: See your Benefit Handbook for details.	Nothing	All charges less applicable cost sharing	$50 Emergency Room Copayment per visit
Hospice Care (including inpatient Respite Care)			
	Nothing	All charges	No charge
Low Protein Foods			
– Up to $5,000 per calendar year	Nothing	All charges	All charges in excess of $5,000
Mental Health Care and Substance Use Disorder Treatment Services			
Inpatient Services – Benefits are provided for the same number of days as the coverage provided for a physical illness	Nothing	All charges	No charge
Outpatient Services – Benefits are provided for unlimited visits	Nothing	All charges less applicable cost sharing	$15 Copayment per visit
Detoxification and Psychopharmacological Services, Psychological Testing and Neuropsychological Assessment Services	Nothing	All charges less applicable cost sharing	$15 Copayment per visit
Partial Hospitalization	Nothing	All charges	No charge
Outpatient Methadone Maintenance			
	Nothing	All charges	No charge
Routine Eye Exam			
– Limited to 1 exam per calendar year	Nothing	All charges less applicable cost sharing	$15 Copayment per visit

HPIC Plan Benefits	Medicare Pays:	Medicare Enhance Pays:	Your Cost Sharing:
Routine Hearing Exam			
– Limited to 1 exam per calendar year	Nothing	All charges less applicable cost sharing	$15 Copayment per visit
Routine Physical Exam			
	Nothing	All charges	No charge
Scalp Hair Prosthetics (Wigs)			
– Up to $350 per calendar year	Nothing	All charges	All charges in excess of $350
Special Formulas for Malabsorption			
	Nothing	All charges	No charge
Speech Language and Hearing Services			
	Nothing	All charges less applicable cost sharing	$15 Copayment per visit
Telemedicine Virtual Visits			
	Nothing	All charges less applicable cost sharing	$15 Copayment per visit

Section 7: What The Plan Does Not Cover

A. No benefits will be provided by the Plan for any of the following:

- Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in the Benefit Handbook, Schedule of Benefits or (if applicable) the Prescription Drug Brochure.
- Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
- Any product or service obtained at an unapproved facility if Medicare requires that the product or service be provided at a Medicare-approved facility. This exclusion applies to liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a Medicare-approved facility.
- Any product or service provided after the date on which your enrollment in the Plan has ended.
- Any charges that exceed the Payment Maximum.
- Any product or services received in a hospital not certified to provide services to Medicare beneficiaries, unless (1) the hospital is outside the United States, (2) the Subscriber's Plan includes benefits for emergency services outside of the United States, and (3) coverage is available under that benefit.
- Any product or service for which no charge would be made in the absence of insurance.

B. Unless covered by Medicare Parts A and B, no Benefits will be provided by the Plan for any of the following:

- Any product or service that is not Medically Necessary.

- Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.
- Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
- Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.
- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven or Investigational.
- Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
- Custodial Care.
- Recovery programs including rest or domiciliary care, sober houses, transitional support services and therapeutic communities.
- Eyeglasses, contact lenses, fittings or examinations. (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery).
- Refractive eye surgery, including but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Hearing aids unless specifically listed as a Covered Service in the Schedule of Benefits.
- Hearing aid batteries.
- Biofeedback.
- Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Service. Aromatherapy, treatment with crystals and alternative medicine. Any of the following types of programs: health resorts, spas recreational programs, camps, outdoor residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs), massage therapy and myotherapy.
- Routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes. Foot orthotics, except as required for the treatment of severe diabetic foot disease or systemic circulatory diseases.
- Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs.)
- Dental Services, including, but not limited to, restorative, periodontal, orthodontic, endodontic, prosthodontic services (including any services related to dentures), or any Dental Services relative to the treatment of temporomandibular joint dysfunction (TMJ), except that (1) the Plan will cover the Medicare Deductible and Coinsurance amount for any Dental Service that has been covered by Medicare and (2) the Plan will cover additional Dental Services if such coverage is purchased by an Employer Group. If your Employer Group has purchased coverage for additional Inpatient Dental Services or Outpatient Oral Surgery, such coverage will be listed in the Schedule of Benefits.

- Infertility services or any related services, supplies, or drugs, including, but not limited to, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection, donor egg procedures (including related egg and inseminated egg procurement), the preservation of eggs or sperm, voluntary sterilization or the reversal of voluntary sterilization.
- Any form or Surrogacy or services for a gestational carrier.
- Ambulance services except as specified in the Benefit Handbook. No benefits will be provided for transportation other than by ambulance.
- Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
- Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
- Any product or service related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Deductible and Coinsurance amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
- Drugs or medications that can be self-administered unless (1) the Employer Group has purchased prescription drug coverage on behalf of the Subscriber, and coverage for such drug or medication is provided for in the Prescription Drug Brochure, (2) the drug or medication is covered by Medicare Parts A or B; or (3) coverage for the drug or medication is mandated by Massachusetts law.
- Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.
- Planned home births.
- Devices or special equipment needed for sports or occupational purposes.
- Charges for any product or service, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this Benefit Handbook.
- Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.
- Telemedicine services involving e-mail, fax or non-secure texting.
- Any service or supply (with the exception of contact lenses) purchased from the internet.
- Services provided by a doula.

Section 8: Important Notices

Medical Emergency: You are always covered for care you need in a medical emergency within the United States. In the event of a medical emergency, you should go to the nearest emergency facility or call 911 or the local emergency number.

Coverage will be subject to the terms, conditions, exclusions and limitations of Medicare-eligible services and supplies, and is subject to change pursuant to Medicare guidelines.

This Plan is only available to Subscribers enrolled through Employer Groups. Coverage under the Plan is effective on the first day of the month chosen by your Employer and renews each year on

your Employer's anniversary date unless terminated in accordance with the terms of the Employer Agreement. Premiums are subject to change as set forth in the Employer Agreement between HPIC and your Employer Group as permitted by law. Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan. To be eligible to enroll, or continue enrollment, in the Plan, an individual must be enrolled in Medicare Part A and Part B and pay any premium required for continued enrollment at all times.

SilverScript®

City of Boston
Aetna Medicare Rx offered by SilverScript
Rx $9/$25/$45

Benefits and Premiums are effective January 1, 2025 through December 31, 2025

SUMMARY OF BENEFITS
PROVIDED BY SILVERSCRIPT INSURANCE COMPANY

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Pharmacy Network	P1
Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)	
Formulary (Drug List)	Classic
Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.	

Beginning 1/1/25, the Centers for Medicare Services (CMS) made the following changes to the standard Part D plan design:

- Reduction to three phases - Deductible, Initial Coverage, and Catastrophic
- Elimination of the Initial Coverage Limit and the Coverage Gap Phase
- Introduction of a $2,000 annual out-of-pocket threshold
- Replacement of the Coverage Gap Discount Program with the Manufacturer Discount Program which will provide a 10% manufacturer discount for brand drugs in the Initial Coverage phase and 20% manufacturer discount for brand drugs in the Catastrophic phase

See below for your specific benefits and cost sharing.

Calendar-Year Deductible for Prescription Drugs	$0
Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.	

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

SilverScript®

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3 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	**Standard**	**Preferred Retail**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$9	$10	$27	$18	$30
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$25	$25	$75	$50	$75
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$45	$45	$135	$115	$135

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

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

Catastrophic Coverage: You pay $0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,000 for covered Part D prescription drugs is reached.

Requirements:

Precertification Applies

Step-Therapy Applies

Non-Part D Supplemental Benefit

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

For more information about Aetna plans, go to **www.aetna.com** or call Member Services toll-free at 1-800-594-9390 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

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).

Aetna Medicare Rx offered by SilverScript's pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban Utah, Suburban West Virginia, Suburban Wyoming. 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 1-855-222-6857 (TTY: 711) or consult the online pharmacy directory at http://www.aetnaretireeplans.com.

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

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

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

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

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.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-855-222-6857, 24 hours a day, 7 days a week. TTY users call 711.

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 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 enhanced drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

Plan Disclaimers

Aetna Medicare Rx offered by SilverScript is a group standalone Medicare Prescription Drug Plan (PDP). This Plan is offered by SilverScript Insurance Company, which has a Medicare contract. SilverScript Insurance Company and Aetna are affiliated companies. Enrollment in the Plan depends on Medicare contract renewal.

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

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

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

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 2025* 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 (http://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.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-594-9390 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-594-9390 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-594-9390 (TTY: 711).

You can also visit our website at http://www.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).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830번으로 문의해 주십시오.

한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

:Arabic
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-307-4830. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-307-4830にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-800-307-4830. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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

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