MASSACHUSETTS STRATEGIC HEALTH GROUP
Town of Medway
Aetna Medicare℠ Plan (PPO)
Medicare (C04) ESA PPO Plan
Rx $9/$15/$30

Benefits and Premiums are effective January 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (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 doctor in order to see you.

Prior Authorizations: Your doctor 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 FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	$0
Annual Maximum Out-of-Pocket Amount Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$300

It will apply to all medical expenses except Vision Reimbursementand Medicare prescription drug coverage that may be available on your plan.

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 per stay

Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay
Outpatient Services & Surgery	$0
Ambulatory Surgery Center	$0
PHYSICIAN SERVICES	**This is what you pay for network & out-of-network providers.**
Primary Care Physician Visits	$10

Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.

Physician Specialist Visits	$10
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers.**
Medicare-covered Preventive Services	$0

• Abdominal aortic aneurysm screenings
• Alcohol misuse screenings and counseling
• Annual wellness visit - One exam every 12 months.
• Bone mass measurements
• Mammography Screening
• Cardiovascular disease screenings
• Cervical Cancer Screenings with Human Papillomavirus (HPV) Test

• Colorectal cancer screenings
• Depression screenings
• Diabetes screenings
• Hepatitis B screening
• Hepatitis C screening
• HIV screenings & HIV Prep
• Lung cancer screening - lung cancer screening with Low Dose Computed Tomography (LDCT).
• Medicare Diabetes Prevention Program
• Medical Nutrition therapy services

• IBT for Cardiovascular Disease • IBT for Obesity • Initial Preventive Physical Exam (IPPE) • Screening Pelvic Exams • Screening Pap Test • Prolonged Preventive Services • Prostate cancer screening • Sexually transmitted infections (STI) screening & High Intensity Behavioral Counseling (HIBC) to Prevent STIs • Counseling to Prevent Tobacco Use	
Immunizations • COVID-19 Vaccine & Administration • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Diabetes self-management training (DSMT) • Glaucoma screening	$0
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$0
Urgently Needed Care; Worldwide	$0
DIAGNOSTIC PROCEDURES*	**This is what you pay for network & out-of-network providers.**
Diagnostic Radiology CT scans	$0
Diagnostic Radiology Other than CT scans	$0
Lab Services	$0
Diagnostic testing & procedures	$0
Outpatient X-rays	$0

HEARING SERVICES	This is what you pay for network & out-of-network providers.
Routine Hearing Screening We cover one exam every twelve months	$0
Medicare Covered Hearing Examination	$10
Hearing Aid Benefit Vendor:	$1,500 once every 24 months NationsHearing
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Medicare Covered Dental*	$10
Non-routine care covered by Medicare.	
VISION SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$10
Diabetic Eye Exams	$0
Medicare Covered Eye Exam	$10
Vision Eyewear Reimbursement Applies to in or out of network	$150 once every 12 months
MENTAL HEALTH SERVICES*	**This is what you pay for network & out-of-network providers.**
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 per stay
Outpatient Mental Health Care Individual visit	$10
Partial Hospitalization	$0
Intensive Outpatient Services	$0
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 per stay

Outpatient Substance Abuse	$10

Individual visit

SKILLED NURSING SERVICES*	**This is what you pay for network & out-of-network providers.**
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-100

Limited to 100 days per Medicare Benefit Period.
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES*	**This is what you pay for network & out-of-network providers.**
Outpatient Rehabilitation Services	$10

(Speech, physical, and occupational therapy)

AMBULANCE SERVICES	**This is what you pay for network & out-of-network providers.**
Ambulance Services	$0

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 SERVICES	**This is what you pay for network & out-of-network providers.**
Transportation (non-emergency)	24 one-way trips with 60 miles allowed per trip

MEDICARE PART B PRESCRIPTION DRUGS*	**This is what you pay for network & out-of-network providers.**
Medicare Part B Prescription Drugs	$0

Medicare Part B Prescription Drugs - Insulin	$0

MEDICARE PART D PRESCRIPTION DRUGS	**This is what you pay for network & out-of-network providers.**
Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.	

ADDITIONAL PROGRAMS AND SERVICES	**This is what you pay for network & out-of-network providers.**
Allergy Shots	$0
Allergy Testing	$10
Blood All components of blood are covered beginning with the first pint.	$0
Cardiac Rehabilitation Services	$10
Intensive Cardiac Rehabilitation Services	$10
Chiropractic Services* Medicare covered benefits only.	$10
Diabetic Supplies* Includes supplies to monitor your blood glucose.	$0
Durable Medical Equipment/ Prosthetic Devices*	$0
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$10
Outpatient Dialysis Treatments*	$0
Podiatry Services Medicare covered benefits only.	$10

Pulmonary Rehabilitation Services	$0
Supervised Exercise Therapy (SET) for PAD Services	$0
Radiation Therapy*	$0
Urine Test Strips Non-Medicare covered	$0
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network & out-of-network providers.**
Fitness Benefit	SilverSneakers®
Healthy Rewards	Covered
Meals Covered up to 14 meals following an inpatient stay.	$0
Resources For Living® For help locating resources for every day needs.	Covered
Smoking and Tobacco Use Cessation Supplies Frequency	$0 unlimited visits every year
Teladoc™ Telemedicine services with a Teladoc™ provider. State mandates may apply.	$0
Telehealth Telemedicine Services. Member cost share will apply based on services rendered.	Covered
Telehealth PCP	$0
Telehealth Specialist	$0
Telehealth Occupational Therapy Services	$10
Telehealth PT and SP Services	$10
Telehealth Other Health care Providers	$0
Telehealth Individual Mental Health	$0

Telehealth Group Mental Health	$0
Telehealth Individual Psychiatric Services	$0
Telehealth Group Psychiatric Services	$0
Telehealth Individual Substance Abuse Services	$10
Telehealth Group Substance Abuse Services	$10
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services	$10
Telehealth Urgent care	$0
Wigs*	$0
Maximum	$350
Frequency	every year
ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network & out-of-network providers.**
Cervical and Vaginal Cancer Screening (non-Medicare covered)	$0

In addition to the Medicare-covered services listed above, we cover one exam every twelve months

Routine Physical Exams	$0
One exam per calendar year	

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Pharmacy Network	P1

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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.

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.

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	$9	$30
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$15	$15	$45	$15	$45
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$30	$30	$90	$30	$90

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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 $2,100 for covered Part D prescription drugs is reached.

Requirements:	
Precertification	Applies
Step-Therapy	Applies

Non-Part D Supplemental Benefit

- Agents when used for the treatment of sexual or erectile dysfunction (ED)

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 a.m. to 9 p.m. EST, Monday through Friday.

Medical Disclaimers

The provider network may change at any time. You will receive notice when necessary.

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.

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 a.m. to 9 p.m. EST, 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 Aetna 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.

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

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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.

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 1-866-241-0357, 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 is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
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.
Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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

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 2026 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 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (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 1-888-267-2637 (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).

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

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Approved By:
Date: