### Section 5: Plans and Premiums With Medicare

Please review this section for the features and premiums of the plans for enrollees with Medicare. If you have family members on your account without Medicare, also review Section 3 (Page 12) for features and premiums of the plan options for non-Medicare enrollees. Be aware, coverage features under the same plan could differ based on Medicare status. Premiums also differ.

<table>
<thead>
<tr>
<th>Prescription Drug Plan Features With Medicare</th>
<th>Express Scripts Medicare Part D Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Brand-Name Deductible per Enrollee</strong></td>
<td>$275 for covered brand-name drugs, including specialty</td>
</tr>
<tr>
<td>(Generic drug costs and non-preferred pharmacy fees do not apply to the deductible.)</td>
<td></td>
</tr>
<tr>
<td><strong>Standard Network Retail/Nursing Home Pharmacy Copayments/Coinsurance per 31-day Supply</strong></td>
<td></td>
</tr>
<tr>
<td>(If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)</td>
<td>Preferred Pharmacies</td>
</tr>
<tr>
<td></td>
<td>Generic: Enrollee pays $10</td>
</tr>
<tr>
<td></td>
<td>Covered brand-name: Enrollee pays $30</td>
</tr>
<tr>
<td></td>
<td>(after deductible)</td>
</tr>
<tr>
<td></td>
<td>Specialty: Enrollee pays the lesser of 13% of the cost or $450</td>
</tr>
<tr>
<td></td>
<td>for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days</td>
</tr>
<tr>
<td></td>
<td>(after deductible); may use any specialty pharmacy</td>
</tr>
<tr>
<td></td>
<td>(non-preferred pharmacy fees do not apply)</td>
</tr>
<tr>
<td><strong>Maximum Day Supply</strong></td>
<td>Retail: Up to 90 days*</td>
</tr>
<tr>
<td></td>
<td>Home delivery: 90 days</td>
</tr>
<tr>
<td></td>
<td>*Prior to acceptance in Express Scripts Medicare Part D plan, maximum retail supply is 31 days</td>
</tr>
<tr>
<td><strong>Home Delivery Copayments/Coinsurance</strong></td>
<td>Low-Cost Generic Drug Program medications: Enrollee pays $9</td>
</tr>
<tr>
<td>(If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)</td>
<td>Generic: Enrollee pays $25</td>
</tr>
<tr>
<td></td>
<td>Covered brand-name: Enrollee pays $75 (after deductible)</td>
</tr>
<tr>
<td></td>
<td>Specialty: Enrollee pays the lesser of 13% of the cost or $450</td>
</tr>
<tr>
<td></td>
<td>for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days</td>
</tr>
<tr>
<td></td>
<td>(after deductible)</td>
</tr>
<tr>
<td><strong>Enrollee’s Maximum Annual Expense</strong></td>
<td>If an enrollee pays a total of $6,550 out of pocket in copayments/coinsurance/deductible for generic, covered brand-name and specialty medications, that enrollee pays nothing for covered medications for the remainder of the year.</td>
</tr>
<tr>
<td>(Non-preferred pharmacy fees do not apply to the maximum annual expense.)</td>
<td></td>
</tr>
</tbody>
</table>
## WITH MEDICARE

You may be eligible for these plans if you are enrolled in Medicare.

### PLAN FEATURES

<table>
<thead>
<tr>
<th>Enrollee Eligibility</th>
<th>Available in any U.S. location</th>
<th>Available in any U.S. location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible per Enrollee</td>
<td>$150</td>
<td>$500</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$1,500 per enrollee (includes deductible, copayments and coinsurance)</td>
<td>$2,500 per enrollee (includes deductible, copayments and coinsurance)</td>
</tr>
<tr>
<td>Lifetime Benefits Maximum per Enrollee</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Health Provider Access</td>
<td>Use network provider (PPO); use any provider that accepts Medicare and the Aetna plan (ESA PPO)</td>
<td>Use any provider that accepts Medicare</td>
</tr>
</tbody>
</table>

### PHYSICIAN, HOSPITAL, SKILLED NURSING AND HOME HEALTH CARE

| Primary Care Physician Office Visit (Includes in-person, phone and video visits.) | Enrollee pays $15 (no deductible) | Enrollee pays $40 after deductible | Enrollee pays $20 per visit for first two visits per year (no deductible); 20% thereafter (after deductible) |
| Specialist Physician Office Visit (Includes in-person, phone and video visits.) | Enrollee pays $25 (no deductible) | Enrollee pays $55 after deductible | Enrollee pays 20% |
| Urgent Care | Enrollee pays $50 (no deductible) | Enrollee pays $40, then 20% after deductible |
| Hospital Services (Inpatient/Outpatient) | Enrollee pays 4% | Enrollee pays 8% | Enrollee pays 20% |
| Hospital Charges for Outpatient Surgery/Preadmission Testing | Enrollee pays 4% | Enrollee pays 8% | Enrollee pays 20% | Enrollee pays 20% |
| Emergency Room Care | Enrollee pays $75 (no deductible); waived if admitted | Enrollee pays $150; waived if admitted |
| Skilled Nursing Facility (Benefit periods vary by plan.) | Enrollee pays 0% after deductible; no visit limit | Enrollee pays 8% after deductible; no visit limit | Enrollee pays 20% (90 days per benefit period); after 90 days, enrollee pays 100% | Enrollee pays 50% (90 days per benefit period); after 90 days, enrollee pays 100% |
| Inpatient Mental Health | Enrollee pays 4% | Enrollee pays 8% | Enrollee pays 20%; no limit on days | Enrollee pays 50%; no limit on days |
| Home Health Care | Enrollee pays 0% after deductible; no visit limit | Enrollee pays 8% after deductible; no visit limit | Enrollee pays 20%; no visit limit |

### Out-of-Network

- **Aetna Medicare Plan**
  - Out-of-Network
- **Medical Mutual Basic**
  - Out-of-Network
- **AultCare PrimeTime Health Plan**
  - Out-of-Network
- **Paramount Elite**
  - Out-of-Network

### Out-of-Pocket Maximum

- **Aetna Medicare Plan**
  - Out-of-Pocket Maximum (Includes prescription drug costs. Amounts included are noted for each plan.)
- **Medical Mutual Basic**
  - Out-of-Pocket Maximum
- **AultCare PrimeTime Health Plan**
  - Out-of-Pocket Maximum
- **Paramount Elite**
  - Out-of-Pocket Maximum

### Enrollee Eligibility

- **Aetna Medicare Plan**
  - Enrollee pays 4%
  - Enrollee pays $25
  - Unlimited
  - Enrollee pays 4%

- **Medical Mutual Basic**
  - Use network provider
  - Enrollee pays 4%
  - $150
  - Out-of-Network
  - Enrollee pays 20%
  - $500
  - In-Network and Out-of-Network
  - Enrollee pays 4%
  - Unlimited

- **AultCare PrimeTime Health Plan**
  - Available in select northeastern Ohio area ZIP codes
  - Available in select northeastern Ohio and southern Michigan area ZIP codes
  - $150
  - $500
  - $1,500 per enrollee (includes deductible, copayments and coinsurance)

- **Paramount Elite**
  - Available in any U.S. location
  - In-Network (PPO) or Out-of-Network
  - Enrollee pays 8%
  - $150
  - Enrollee pays $150; waived if admitted
  - $500
  - Enrollee pays $40 (no deductible)
  - Enrollee pays 20%
  - $2,500
  - In-Network and Out-of-Network
  - Enrollee pays 8%
  - $150
  - Enrollee pays $75 (no deductible); waived if admitted
  - $2,500
  - Enrollee pays $40 (no deductible)
  - Enrollee pays 20%

### Enrollee Eligibility

- **Aetna Medicare Plan**
  - Enrollee pays 4%
  - Enrollee pays $25
  - Unlimited
  - Enrollee pays 4%

- **Medical Mutual Basic**
  - Use network provider
  - Enrollee pays 4%
  - $150
  - Out-of-Network
  - Enrollee pays 20%
  - $500
  - In-Network and Out-of-Network
  - Enrollee pays 4%
  - Unlimited

- **AultCare PrimeTime Health Plan**
  - Available in select northeastern Ohio area ZIP codes
  - Available in select northeastern Ohio and southern Michigan area ZIP codes
  - $150
  - $500
  - $1,500 per enrollee (includes deductible, copayments and coinsurance)

- **Paramount Elite**
  - Available in any U.S. location
  - In-Network (PPO) or Out-of-Network
  - Enrollee pays 8%
  - $150
  - Enrollee pays $150; waived if admitted
  - $500
  - Enrollee pays $40 (no deductible)
  - Enrollee pays 20%
  - $2,500
  - In-Network and Out-of-Network
  - Enrollee pays 8%
  - $150
  - Enrollee pays $75 (no deductible); waived if admitted
  - $2,500
  - Enrollee pays $40 (no deductible)
  - Enrollee pays 20%

### Enrollee Eligibility

- **Aetna Medicare Plan**
  - Enrollee pays 4%
  - Enrollee pays $25
  - Unlimited
  - Enrollee pays 4%

- **Medical Mutual Basic**
  - Use network provider
  - Enrollee pays 4%
  - $150
  - Out-of-Network
  - Enrollee pays 20%
  - $500
  - In-Network and Out-of-Network
  - Enrollee pays 4%
  - Unlimited

- **AultCare PrimeTime Health Plan**
  - Available in select northeastern Ohio area ZIP codes
  - Available in select northeastern Ohio and southern Michigan area ZIP codes
  - $150
  - $500
  - $1,500 per enrollee (includes deductible, copayments and coinsurance)

- **Paramount Elite**
  - Available in any U.S. location
  - In-Network (PPO) or Out-of-Network
  - Enrollee pays 8%
  - $150
  - Enrollee pays $150; waived if admitted
  - $500
  - Enrollee pays $40 (no deductible)
  - Enrollee pays 20%
  - $2,500
  - In-Network and Out-of-Network
  - Enrollee pays 8%
  - $150
  - Enrollee pays $75 (no deductible); waived if admitted
  - $2,500
  - Enrollee pays $40 (no deductible)
  - Enrollee pays 20%
**Plan Features for 2021**

**WITH MEDICARE**

You may be eligible for these plans if you are enrolled in Medicare.

<table>
<thead>
<tr>
<th>Plan Features for 2021</th>
<th>Aetna Medicare Plan* (Medicare Advantage PPO)</th>
<th>Medical Mutual Basic (Indemnity or PPO)</th>
<th>AutoCare PrimeTime Health Plan (Medicare Advantage HMO-PPO)</th>
<th>Paramount Elite (Medicare Advantage HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network (PPO) or Extended Service Area (ESA PPO)</td>
<td>Out-of-Network (PPO)</td>
<td>In-Network and Indemnity*1</td>
<td>Out-of-Network*2</td>
</tr>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
<td>If you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, any applicable copayment/coinsurance/deductible will apply to care rendered for the existing medical condition.</td>
<td>Enrollee pays 0% (no deductible)</td>
<td>Enrollee pays 0% (no deductible)</td>
<td>Enrollee pays 0% (no deductible)</td>
</tr>
<tr>
<td>Limited designated services such as routine physical, bone density screening, mammogram, colorectal screening, Pap smear and immunizations/ inoculations; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations. Contact the plan for details.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUTPATIENT SERVICES</strong></td>
<td>Diagnostic X-ray/Lab Testing</td>
<td>Enrollee pays 4% for diagnostic X-ray after deductible; 0% for lab testing (no deductible)</td>
<td>Enrollee pays 8% for diagnostic X-ray after deductible; 0% for lab testing after deductible</td>
<td>Enrollee pays 4% for diagnostic X-ray after deductible; 0% for lab testing after deductible</td>
</tr>
<tr>
<td>(Includes in-person, phone and video visits.)</td>
<td>Outpatient Mental Health</td>
<td>Enrollee pays $25 (no deductible); no visit limit</td>
<td>Enrollee pays $55 after deductible; no visit limit</td>
<td>Enrollee pays $25 after deductible; no visit limit</td>
</tr>
<tr>
<td><strong>ADDITIONAL SERVICES</strong></td>
<td>Dental Care</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>(Some plans may also offer hearing discounts and discounts on natural products and services. Contact the plan for details.)</td>
<td>Vision Care</td>
<td>Enrollee pays 0% for annual routine eye exam; eyewear discounts available at participating providers</td>
<td>No coverage</td>
<td>Enrollee pays 0% for annual routine eye exam</td>
</tr>
<tr>
<td>Fitness/Weight Management</td>
<td>SilverSneakers membership; discounts on weight management services</td>
<td>Discount membership to Curves and gyms in the GlobalFit network; discounts on weight management services</td>
<td>Silver&amp;Fit Exercise &amp; Healthy Aging Program includes free access to a participating fitness center or select YMCA</td>
<td>SilverSneakers membership</td>
</tr>
<tr>
<td>Teledicine</td>
<td>Cleveland Clinic’s Express Care Online visit covered at same level as in-network primary care physician or specialist physician office visit</td>
<td>Teledoc visit covered at same level as in-network primary care physician or specialist physician office visit</td>
<td>Proliﬁda EnTelmand visit covered at same level as primary care physician or specialist physician office visit</td>
<td></td>
</tr>
</tbody>
</table>

*Providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for the excess charges.

*Indemnity and out-of-network payments are based on allowed/noncontracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers or providers that do not accept Medicare assignment charge in excess of these amounts, the enrollee is responsible for the excess charges.

**Benefits are payable after Medicare payments.**