2024 | Summary of Benefits

SOUTHERN CALIFORNIA EDISON

Sponsored by Aetna Medicare Plan (HMO)

Medicare (S05) HMO (MAP) Plan

Keep in mind

This is just a summary. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). You can request a copy of the SOC/EOC by contacting:

Member Services

1-800-307-4830 (TTY: 711)

Hours are 5 AM to 6PM PT, Monday through Friday.

This is a summary of the services we cover from January 1, 2024 through December 31, 2024.

Are you eligible to enroll?

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

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area

Service area: A complete list of service areas can be found in the *Evidence of Coverage* (EOC).

What You Should Know

Plan costs & information	In-network
Premium	Please contact your former employer 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	$1,190
	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 doesn't count toward your MOOP.

PRIMARY BENEFITS	Your costs for in-network care
Hospital Care*	
Inpatient Hospital Care	$250 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
Physician Services	
Primary Care Physician Visits	$30 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.
Physician Specialist Visits	$30
Preventive Services	
Abdominal aortic aneurysm screenings	$0
Alcohol misuse screenings and counseling	$0
Annual well visit - one exam every 12 months	$0
Bone mass measurements	$0

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PRIMARY BENEFITS	Your costs for in-network care
Preventive Services (continued)	
Breast exams	$0
Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; one annual mammogram for members age 40 and over	$0
Cardiovascular behavior therapy	$0
Cardiovascular disease screenings	$0
Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)	$0
Depression screenings	$0
Diabetes screenings	$0
HBV infection screening	$0
Hepatitis C screening tests	$0
HIV screenings	$0
Lung cancer screenings and counseling	$0
Medicare Diabetes Prevention Program (MDPP)	$0
Nutrition therapy services	$0
Obesity behavior therapy	$0
Pelvic exams - one routine GYN visit and Pap smear every 24 months	$0
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PRIMARY BENEFITS	Your costs for in-network care
Preventive Services (continued)	
Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service	$0
Prostate cancer screenings (PSA) - for all male patients aged 50 or older (coverage begins the day after 50th birthday)	$0
Sexually transmitted infections screening and counseling	$0
Tobacco use cessation counseling	$0
“Welcome to Medicare” preventive visit	$0
Immunizations	
Flu	$0
Hepatitis B	$0
Pneumococcal	$0
Additional Medicare Preventive Services	
Barium enema - one exam every 12 months	$0
Diabetes self-management training (DSMT)	$0
Digital rectal exam (DRE)	$0
EKG following welcome exam	$0
Glaucoma screening	$0

PRIMARY BENEFITS	Your costs for in-network care
Emergency and Urgent Medical Care	
Emergency Care (includes services worldwide)	$125 (waived if admitted immediately)
Urgent Care (includes services worldwide)	$30
Diagnostic Procedures*	
Diagnostic Radiology (CT scans)	$0
Diagnostic Radiology (other than CT scans)	$0
Diagnostic Testing and Procedures	$0
Lab Services	$0
Outpatient X-rays	$0
Hearing Services	
Hearing Exam (routine)	$0 Coverage: one exam every twelve months
Hearing Exam (Medicare-covered)	$30
Hearing Aid Reimbursement	$500 once every 12 months
Dental Services*	
Dental Services	$30 Medicare-covered benefits only
Vision Services	
Eye Exam (routine)	$0 Coverage: one exam every twelve months
Diabetic Eye Exam	$0
Eye Exam (Medicare-covered)	$30

PRIMARY BENEFITS	Your costs for in-network care
Mental Health Services*	
Inpatient Mental Health Care	$250 per stay The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Mental Health Care	$30 (individual sessions) $30 (group sessions)
Partial Hospitalization	$30
Inpatient Substance Abuse	$250 per stay The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Substance Abuse	$30 (individual sessions) $30 (group sessions)
Skilled Nursing Services*	
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

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PRIMARY BENEFITS	Your costs for in-network care
Skilled Nursing Services* (continued)	
	period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Outpatient Rehabilitation Services	
Occupational Therapy Rehabilitation Services	$30
Physical and Speech Therapy Rehabilitation Services	$30
Ambulance* and Transportation Services	
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 (non-emergency)	Covered Coverage: up to 24 one-way rides per year with 60 miles allowed per trip.

PRIMARY BENEFITS	Your costs for in-network care
Medicare Part B Prescription Drugs*	
Medicare Part B Prescription Drugs	$0
***These benefits may require prior authorization.**	

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in-network care
ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	
Acupuncture Services	$30 Medicare-covered benefits only
Allergy Shots	$0
Allergy Testing	$30
Blood	$0 All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	$30
Chiropractic Services*	$20 Medicare-covered benefits only
Diabetic Supplies*	$0 Includes supplies to monitor your blood glucose from LifeScan, or from a non-preferred provider when a prior authorization is received.
Durable Medical Equipment (DME)*	$0
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.
Intensive Cardiac Rehabilitation Services	$30
Medical Supplies*	Your cost share is based upon the provider of services

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ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in-network care
ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)(Continued)	
Outpatient Dialysis Treatments*	$0
Podiatry Services	$30 Medicare-covered benefits only
Prosthetic Devices*	$0
Pulmonary Rehabilitation Services	$20
Supervised Exercise Therapy (SET) for PAD	$20
Radiation Therapy*	$0
***These benefits may require prior authorization.**	

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare)	
Fitness Program	SilverSneakers®
Healthy Rewards	Covered
Meals	$0 After discharge from an inpatient stay to your home, you may be eligible to receive up to 28 home-delivered meals over a 14-day period.
Over-the-Counter Items	$0
Over-the-Counter Allowance	$45
Over-the-Counter Frequency	quarterly
Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Resources for Living®	This program is offered to help you locate resources for everyday needs.
Acupuncture Services (non-Medicare covered)	$30 Supplemental acupuncture services are covered for up to thirty visits every year per year under the following circumstance(s): in lieu of anesthesia and for treatment of chronic pain.

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ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare) (continued)	
Chiropractic Services (non-Medicare covered)	$20
	Supplemental chiropractic services are covered for up to thirty visits every year per year.
Frequency	thirty visits every year
Teladoc™	$0
	Telemedicine services with a Teladoc provider. State mandates may apply.
Telehealth Mental Health services provided by MD live	$0
Telehealth PCP	$30
Telehealth Specialist	$30
Telehealth Occupational Therapy Service	$30
Telehealth PT and SP Services	$30
Telehealth Other Health Care Providers	$30
Telehealth Individual Mental Health*	$30
Telehealth Group Mental Health*	$30
Telehealth Individual Psychiatric Services*	$30
Telehealth Group Psychiatric	$30

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ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare) (continued)	
Services*	
Telehealth Individual Substance Abuse Services*	$30
Telehealth Group Substance Abuse Services*	$30
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services*	$30
Telehealth Urgent Care	$30
Physical Exam	$0 A routine physical exam is offered once per calendar year.
In-Home Support Services	In-Home Support Provides in home help for every day needs and activities of daily living.
Coverage Type	Post Discharge
Number of Hours	6 hours
Frequency	per discharge
Vendor	The Helper Bees
Podiatry Services (non-Medicare covered)	$30 Supplemental podiatry services are

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ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare) (continued)	
	covered.
Wigs	$0
Maximum	$400
Frequency	one wig every year
***These benefits may require prior authorization.**	

MEDICAL DISCLAIMERS

For more information about Aetna plans, go to SCEMAPlans.AetnaMedicare.com or call Member Services toll-free at **1-800-307-4830** (TTY: 711). Hours are 5 AM to 6 PM PT, Monday through Friday.

Not all HMO plans are available in all areas.

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 **1-800-307-4830** (TTY: 711). Hours are 5 AM to 6PM PT, Monday through Friday.

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

- Services not performed by your Aetna Medicare network doctor, except in an emergency or urgent situation
- 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

PLAN DISCLAIMERS

Aetna Medicare is a HMO 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.

PLAN DISCLAIMERS

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

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a compliant 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 2024* 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 SCEMAPlans.AetnaMedicare.com . As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

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

Y0001_GRP_5553_2024_M

Form Approved
OMB#0938-1421

Multi-Language Insert

Multi-language Interpreter Services

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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637。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 1-888-267-2637。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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 번으로 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 1-888-267-2637. 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 1-888-267-2637 . 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 1-888-267-2637. 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 1-888-267-2637. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-888-267-2637. 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 1-888-267-2637. 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 1-888-267-2637. 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、1-888-267-2637. 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 1-888-267-2637. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

Y0001_NR_30475b_2023_C

Form CMS-10802
(Expires 12/31/25)

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

傳統漢語(中文) (CHINESE): 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。