Aetna Medicare Plan (PPO) offered by Aetna Medicare

Annual Notice of Changes for 2023

You are currently enrolled as a member of Aetna Medicare Plan (PPO). Next year, there will be some changes to the plan's costs and benefits. ***Please see page 1 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage* and the *Schedule of Cost Sharing*, which is located on our website at Oxy.AetnaMedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage* and/or *Schedule of Cost Sharing*.

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices – Your coverage is offered through your former employer/union/trust
It is important that you carefully consider your decision before dropping your coverage with Oxy. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans.

☐ Contact your plan benefits administrator to see if there are other options available.

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

OMB Approval 0938-1051 (Expires: February 29, 2024)
GRP_ANOC_2023_R2_27996-4_31100-1_27999-1_31151-1
Master Plan ID: 0000994, 0005527
Occidental Petroleum Corporation

3. **CHOOSE:** Decide whether you want to change your plan

   - If you want to keep the same Aetna Medicare plan, your plan benefits administrator will give you instructions if there is any action you need to take to remain enrolled.
   - You can change your coverage during your former employer/union/trust's open enrollment period. Your plan benefits administrator will tell you what other plan choices might be available to you under your group retiree coverage.
   - You can switch to an individual Medicare health plan or to Original Medicare; however, this would mean dropping your group retiree coverage with Oxy. As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your former employer/union/trust's plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible sin cargo en español.
- Please contact our Member Services at the telephone number on your member ID card or call our general Member Services at 1-866-539-6750 for additional information. (TTY users should call 711.) Hours are 8 AM to 9 PM ET, Monday through Friday.
- This document may be available in other formats such as braille, large print or other alternate formats. Please contact Member Services for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aetna Medicare Plan (PPO)

- Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.
- When this document says "we," "us," or "our," it means Aetna Medicare. When it says "plan" or "our plan," it means Aetna Medicare Plan (PPO).

Y0001_ANOC23_M

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Aetna Medicare Plan (PPO) in several important areas. **Please note this is only a summary of changes.**

Cost	2022 (this year)	2023 (next year)
Deductible	**No Deductible**	**No Deductible**
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network and out-of-network providers combined: **$2,000**	From network and out-of-network providers combined: **$2,000**
Doctor office visits	Primary care visits: **$30** copay per visit. Specialist visits: **$40** copay per visit.	Primary care visits: **$30** copay per visit. Specialist visits: **$40** copay per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**$120 per stay**	**$120 per stay**
Part D prescription drug coverage (See Section 1.5 for details.)	**Deductible:** No Deductible *Preferred cost-sharing* (30-day supply) during the Initial Coverage Stage: **Generic:** You pay $9 **Preferred Brand:** You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug **Non-Preferred Brand:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug	**Deductible:** No Deductible *Preferred cost-sharing* (30-day supply) during the Initial Coverage Stage: **Generic:** You pay $9 **Preferred Brand:** You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug **Non-Preferred Brand:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug

Cost	2022 (this year)	2023 (next year)
	Specialty: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug *Standard cost-sharing* (30-day supply) during the Initial Coverage Stage: **Generic:** You pay $10 **Preferred Brand:** You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug **Non-Preferred Brand:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug **Specialty:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug	**Specialty:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug *Standard cost-sharing* (30-day supply) during the Initial Coverage Stage: **Generic:** You pay $10 **Preferred Brand:** You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug **Non-Preferred Brand:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug **Specialty:** You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Your coverage is provided through a contract with your former employer/union/trust. Your plan benefits administrator will provide you with information about your plan premium (if applicable).
You must also continue to pay your Medicare Part B premium.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles, if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) and costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$2,000**	**$2,000** Once you have paid $2,000 out-of-pocket for covered services, you will pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider and Pharmacy Networks

An updated *Provider and/or Pharmacy Directory* is located on our website at Oxy.AetnaMedicare.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a *Provider and/or Pharmacy Directory*.

There are changes to our network of providers for next year. **Please review the *2023 Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**
There are changes to our network of pharmacies for next year. **Please review the *2023 Pharmacy Directory* to see if your pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our

providers affects you, please contact Member Services so we may assist.

Section 1.4 Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Dental services (due to an accident)	Dental services (due to an accident) is not covered.	You pay a $40 copay for each covered accidental dental care service.
Pulmonary rehabilitation services	You pay a $30 copay for each Medicare-covered service.	You pay a $20 copay for each Medicare-covered service.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services	You pay a $30 copay for each Medicare-covered service.	You pay a $20 copay for each Medicare-covered service.
Telehealth additional services — diabetes self-management training	Additional telehealth services are not covered.	You pay a $0 copay for each additional telehealth service.
Telehealth additional services — kidney disease education	Additional telehealth services are not covered.	You pay a $0 copay for each additional telehealth service.
Telehealth additional services — occupational therapy services	Additional telehealth services are not covered.	You pay a $40 copay for each additional telehealth service.
Telehealth additional services — opioid treatment	Additional telehealth services are not covered.	You pay a $40 copay for each additional telehealth service.
Telehealth additional services — outpatient substance abuse (individual sessions)	Additional telehealth services are not covered.	You pay a $40 copay for each additional telehealth service.
Telehealth additional services — outpatient substance abuse (group sessions)	Additional telehealth services are not covered.	You pay a $40 copay for each additional telehealth service.
Telehealth additional services — physical therapy and speech therapy	Additional telehealth services are not covered.	You pay a $40 copay for each additional telehealth service.

Section 1.5 Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. Please note we have changed the name of your formulary for 2023. You can find the formulary name in the *2023 Prescription Drug Schedule of Cost Sharing*.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage
Your cost sharing in the initial coverage stage may be changing from copayment to coinsurance *or* coinsurance to copayment. Please see the following chart for the changes from 2022 to 2023.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard or preferred cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in the *2023 Prescription Drug Schedule of Cost Sharing* included in this packet. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** Generic: You pay $10 Preferred Brand: You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug Non-Preferred Brand: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug Specialty: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug **Preferred cost sharing** Generic: You pay $9 Preferred Brand: You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug Non-Preferred Brand: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug Specialty: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** Generic: You pay $10 Preferred Brand: You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug Non-Preferred Brand: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug Specialty: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug **Preferred cost sharing** Generic: You pay $9 Preferred Brand: You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug Non-Preferred Brand: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug Specialty: You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug
	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines — Our plan covers most Part D vaccines at no

cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin — You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 If you want to stay in Aetna Medicare Plan (PPO)

Your plan benefits administrator will tell you if you need to do anything to stay enrolled in your Aetna Medicare Plan.

Section 2.2 If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan. Your plan benefits administrator will let you know what options are available to you under your group retiree coverage.
- You can switch to an individual Medicare health plan.
- --*OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

It is important that you carefully consider your decision before dropping your coverage with Oxy. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans. Call OxyLink at 800-699-6903 for information about dropping your coverage.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Aetna Medicare Plan (PPO) also known as the Oxy Medicare Advantage PPO Plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Aetna Medicare Plan (PPO) also known as the Oxy Medicare Advantage PPO Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

You may be able to change to a different plan during your former employer/union/trust's open enrollment period. Your plan may allow you to make changes at other times as well. Your plan benefits administrator will let you know what other plan options may be available to you.

Are there other times of the year to make a change?
As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your former employer/union/trust's plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time during the year.

It is important that you carefully consider your decision before dropping your coverage with Oxy. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans. Call OxyLink at 800-699-6903 for information about dropping your coverage.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIP at the phone number in **Addendum A** at the back of the *Evidence of Coverage*.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- ***"Extra Help" from Medicare.*** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Many states have a program called the State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in **Addendum A** at the back of the *Evidence of Coverage*).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription

cost-sharing assistance through the ADAP for your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP for your state (the name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage*).

SECTION 6 Questions?

Section 6.1 Getting Help from Aetna Medicare Plan (PPO)

Questions? We're here to help. Please call Member Services at the telephone number on your member ID card or call our general Member Services at 1-866-539-6750. (TTY only, call 711.) We are available for phone calls 8 AM to 9 PM ET, Monday through Friday. Calls to these numbers are free.

Read your *2023 Evidence of Coverage* (it has details about next year's benefits and costs)
This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* and the *Schedule of Cost Sharing* for Aetna Medicare Plan (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at Oxy.AetnaMedicare.com. The *Schedule of Cost Sharing* lists the out-of-pocket cost share for your plan; a copy is included in this envelope. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website
You can also visit our website at Oxy.AetnaMedicare.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).

Section 6.2 Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)
You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website
You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*
You can read the *Medicare & You 2023* 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 (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

See the *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 Aetna 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.

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

Aetna Medicare's pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Suburban Illinois, Urban Kansas, Suburban and Rural Michigan, Urban Michigan, Urban Missouri, Rural North Dakota, 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 the number on your ID card (TTY: 711) or consult the online pharmacy directory at Oxy.AetnaMedicare.com.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

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.

繁體中文 (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。

How we guard your privacy

What personal information is — and what it isn't
By "personal information," we mean information that can be used to identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.
How we get information about you
We get information about you from many sources, including you. We also get information from your employer, other insurers, or health care providers like doctors.
When information is wrong
Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.
How we use this information
When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your OK when we do. We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work. This means we may share your information with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.
When we need your permission
There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices, which took effect October 10, 2020. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, just visit our member website or call the toll-free number on your ID card.

Aetna Medicare Plan (PPO) Member Services

Method	Member Services – Contact Information
CALL 	The number on your member ID card or 1-866-539-6750. Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers.
TTY 	711 Calls to this number are free. Hours of operation are 8 AM to 9 PM ET, Monday through Friday.
WRITE 	Aetna Medicare PO Box 7082 London, KY 40742
WEBSITE 	Oxy.AetnaMedicare.com

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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750。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 1-866-539-6750。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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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 1-866-539-6750. 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、1-866-539-6750. 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 1-866-539-6750. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

Y0001_NR_30475a_2023_C