



**Aetna MedicareSM Plan (PPO)
with Aetna Medicare Rx[®] Plan**

Focus on you

Information packet 2020

Your guide to getting more from your plan

aetnaretireplans.com

GRP_4001_2283_M 08/2019

 **aetna**TM
medicare solutions

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Shouldn't your Medicare plan give you the advantage?

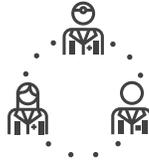
We understand you want to make the best choice for your Medicare coverage. So let's start with what matters most.

Your confidence



We have a legacy of caring for the whole person, providing care, trust and access to Medicare coverage for more than 50 years.

Your doctors



Our nationwide provider coverage makes it easier to see the doctors and hospitals you trust most.

Your prescriptions



Our plans cover many of the most commonly prescribed drugs. And you can get many of them delivered right to your door with the CVS Caremark Mail Service Pharmacy™ service.

First things first. Does your doctor accept our plans?

Chances are they may. To find out for sure, simply give them the plan name and the name of your former employer, union or trust .



Looking for a network doctor?

Our **online directory** has the most up-to-date list of providers in our network. For **PPO plans**, you can see providers outside our network. They just have to be eligible to receive Medicare payments and accept your plan. But keep in mind: you may pay a higher cost share.

To find a network doctor or hospital, visit **[aetnaretireeplans.com](https://www.aetnaretireeplans.com)**.

Once there, follow the search instructions for plans offered through an employer or group sponsor.

To find a provider in your area that accepts Medicare payment, stop by **[medicare.gov](https://www.medicare.gov)**.

Questions or concerns? We're here to help. We can confirm if your doctor accepts our plans or help you find a provider nearby to meet your needs.

Just call us at **1-800-307-4830 (TTY:711)**.

We're here 8 a.m. to 6 p.m. local time, Monday through Friday.

Why Aetna Medicare Advantage?

Each plan we offer is built to help you get more from your Medicare benefits.

A boost beyond Original Medicare

Our plans cover everything Original Medicare does, along with other things it doesn't. These include:



Additional preventive care benefits



Annual preventive care reminders for important health screenings



Are you eligible for our plans?

You're eligible to enroll if:

- You're entitled to Original Medicare Part A
- You're enrolled in Original Medicare Part B
- You continue to pay your Part A and Part B premiums, if applicable
- You live in the plan's service area

If you don't have Original Medicare Part A, contact your employer, union or trust and ask about our Medicare Part B-only plan. Your acceptance is guaranteed as long as you meet the eligibility requirements. For complete information, be sure to refer to your plan documents.

Support for the whole you

You'll also get other benefits, programs and services to help you reach your best health and make life easier.



The Resources For Living[®] program

If you're looking for local help, we can connect you to a wide range of services in your area — from personal care, housekeeping and maintenance to caregiver relief, and so much more.

Informed Health[®] Line

Need a quick answer to a health question? Have a concern that can't wait until you see your doctor? You can talk to one of our registered nurses anytime, day or night.*

Case management

These programs can help you manage chronic conditions and navigate complex medical issues. If you qualify, we'll assign you a case manager. As your health advocate, they'll work with you and your doctors to support your care plan.

*While only your doctor can diagnose, prescribe or give medical advice, our Informed Health Line nurses can provide information on more than 5,000 topics. Contact your doctor first with any questions regarding your health care needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.



Why Aetna Medicare Advantage with prescription drug coverage?

A plan with prescription drug benefits can help cover the cost of your medicine.

One plan for medical and medicine

Our all-in-one plan combines medical benefits with prescription drug coverage. So you'll have just one plan and one member ID card for your medical and prescription drug needs. And the total premium you pay may be lower with this type of plan.



Are your prescription drugs covered?

Our plan covers many of the most commonly prescribed generic and brand-name drugs.

To find your medicine in our formulary (drug list):

- Flip to your plan's Plan Design and Benefits in the "A closer look" section
- Write down the formulary name and the plan's tier structure (for example, 3-tier, 5-tier, etc.) shown under "Pharmacy — Prescription Drug Benefits"
- Go to [aetnaretireeplans.com](https://www.aetnaretireeplans.com)
- Click "Manage your prescription drugs"
- Choose your formulary name from the drop-down list

Don't have access to a computer or the Internet? Just call us at **1-800-307-4830 (TTY: 711)**. We're here 8 a.m. to 6 p.m. local time, Monday through Friday.

Having trouble paying for your prescription drugs?

If your income is limited, you may qualify for Extra Help to pay for your medicine. To find out if you qualify, you can:

- Call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**, 7 a.m. to 7 p.m. local time, Monday through Friday
- Contact your state Medicaid office

Other ways to save

The Medicare Coverage Gap Discount Program gives manufacturer discounts on brand-name drugs to Part D members who:

- Reach the coverage gap
- Don't get Extra Help

If your plan doesn't include added coverage during the coverage gap phase, for covered brand-name drugs, a discount will be applied when the pharmacy bills you.



A hassle-free pharmacy experience

Our pharmacy network includes national chains as well as local options for your prescription drugs.



Finding a network pharmacy is easy

Just visit aetnaretireeplans.com.

Once there:

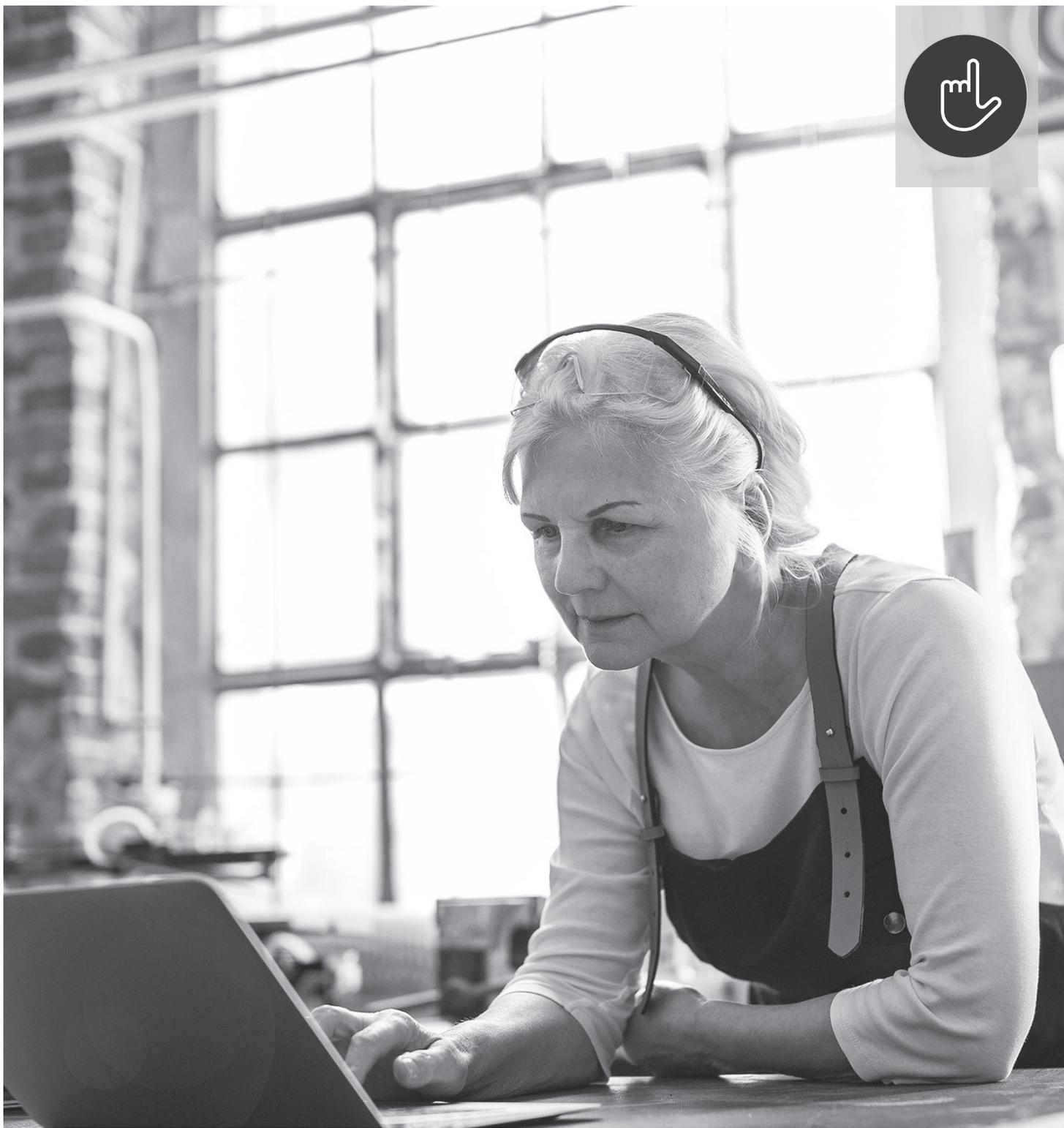
- Choose "Find a doctor, pharmacy or other provider"
- Click "Find a pharmacy that accepts my plan" then "Find a network pharmacy"
- Follow the search instructions for plans offered through an employer/retiree plan

Don't have access to a computer or the Internet? Just call us at **1-800-307-4830 (TTY: 711)**. We're here 8 a.m. to 6 p.m. local time, Monday through Friday.

Get your medicine delivered to your door



With CVS Caremark Mail Service Pharmacy, standard shipping is always free. Your medicine is securely packed. Then it's mailed quickly and safely to you. Registered pharmacists check all orders for accuracy. If you have questions about your medicine, you can call them anytime.



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Check it out

Your benefits at a glance

Benefits at a glance

The chart below provides a snapshot of your plan's features. You'll find more detailed benefits info in the "A closer look" section of this packet.

	Aetna Medicare SM Plan (PPO)
Ability to use providers out of network	✓*
No referrals needed for specialists	✓
Includes all Medicare Parts A and B medical benefits	✓
Offers benefits, programs and services beyond Original Medicare	✓
Covers unlimited inpatient hospital days	✓
Covers emergency medical care worldwide	✓
No waiting period for pre-existing medical conditions	✓
Includes a member website for claim searches	✓

*Providers must agree to accept our reimbursement rates when they join our network. You'll usually pay a lower cost share when you use an in-network provider. If you see an out-of-network provider, you may pay a higher share of the cost for their services. Before you go to an out-of-network provider, make sure they're eligible to receive Medicare payments and are willing to accept your plan. 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.

About your plan

Aetna Medicare Plan (PPO)

A PPO is a preferred provider organization plan. It gives you more flexibility when choosing a doctor.

You can see any provider, in or out of network. They just have to be licensed, eligible to receive Medicare payments and willing to accept your plan. **But you'll generally pay less for your care when you see a provider in our network.**

With a PPO plan, you have the option to choose a primary care physician. But when we know who your doctor is, we can better support your care.

For more detailed info on what your plan offers, see the "A closer look" section of this packet.



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A closer look

Plan Design and Benefits
Aetna Medicare Plan (PPO)

Aetna Medicare Plan (PPO)

The Plan Design and Benefits outlines expected costs for services and describes the benefits package. These details affect what you'll pay for your care. So be sure to review all the pages in this section.



Benefits and Premiums are effective January 1 , 2020 through December 31, 2020

PLAN DESIGN AND BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
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Annual Deductible	\$400	\$700
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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.

Network services exempt from Deductible:

annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, additional Medicare preventive care services, emergency room, emergency ambulance services, urgently needed care.

Out-of-network services exempt from Deductible:

annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care and additional Medicare preventive care services, emergency room, emergency ambulance and urgently needed care.

Annual Maximum Out-of-Pocket Amount	Network Services:	Network and out-of-network services:
	\$3,400	\$5,000 for in and out-of-network services combined

Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Primary Care Physician Selection	Optional	Not Applicable
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There is no requirement for member pre-certification. Your provider will do this on your behalf.



Referral Requirement	None	
Annual Wellness Exams	0%	35%
One exam every 12 months.		
Routine Physical Exams	0%	35%
Medicare Covered Immunizations	0%	0%
Pneumococcal, Flu, Hepatitis B		
Routine GYN Care (Cervical and Vaginal Cancer Screenings)	0%	35%
One routine GYN visit and pap smear every 24 months.		
Routine Mammograms (Breast Cancer Screening)	0%	35%
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.		
Routine Prostate Cancer Screening Exam	0%	35%
For covered males age 50 & over, every 12 months.		
Routine Colorectal Cancer Screening	0%	35%
For all members age 50 & over.		
Routine Bone Mass Measurement	0%	35%
Medicare Diabetes Prevention Program (MDPP)	0%	35%
12 months of core session for program eligible members with an indication of pre-diabetes.		
Routine Eye Exams	0%	35%
One annual exam every 12 months.		
Routine Hearing Screening	0%	35%
One exam every 12 months.		
Additional Medicare Preventive Services	0%	35%

- Ultrasound screening for abdominal aortic aneurysm (AAA)



- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening



Primary Care Physician Visits	\$25	35%
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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	\$50	35%
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Outpatient Diagnostic Laboratory	10%	35%
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Outpatient Diagnostic X-ray	10%	35%
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Outpatient Diagnostic Testing	10%	35%
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Outpatient Complex Imaging	10%	35%
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Urgently Needed Care; Worldwide	\$50	\$50
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Emergency Care; Worldwide (waived if admitted)	\$65	\$65
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Ambulance Services	\$150	35%
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Observation Care

Your cost share for Observation Care is based upon the services you receive.



Inpatient Hospital Care	\$200 copay per day, day(s) 1-5	35% per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Surgery	20%	35%
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Blood	All components of blood are covered beginning with the first pint.	
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Inpatient Mental Health Care	\$200 copay per day, day(s) 1-5	35% per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Mental Health Care	\$40	35%
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Inpatient Substance Abuse	\$200 copay per day, day(s) 1-5	35% per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Outpatient Substance Abuse	\$40	35%
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Skilled Nursing Facility (SNF) Care	0% coinsurance, day(s) 1-20; 20% coinsurance, day(s) 21-100	35%
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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.

Home Health Agency Care	0%	35%
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Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
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Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	20%	35%
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Cardiac Rehabilitation Services	\$50	35%
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Pulmonary Rehabilitation Services	\$30	35%
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Radiation Therapy	20%	35%
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Chiropractic Services	20%	35%
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Limited to Original Medicare - covered services for manipulation of the spine.

Durable Medical Equipment/ Prosthetic Devices	20%	35%
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Podiatry Services	\$50	35%
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Limited to Original Medicare covered benefits only.

Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	0%	35%
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Diabetic Eye Exams	0%	35%
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Outpatient Dialysis Treatments	20%	20%
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Medicare Part B Prescription Drugs	20%	35%
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 Aetna MedicareSM Plan (PPO)
 Medicare (C05) PPO Plan
 Custom Rx \$10/\$20/\$45/\$95/\$95

Medicare Covered Dental	\$50	35%
Non-routine care covered by Medicare.		



Fitness Benefit	Silver Sneakers
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Hearing Aid Reimbursement	\$500 once every 36 months
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Resources for Living	Covered
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For help locating resources for every day needs.

See next page for Pharmacy-Prescription Drug Benefits.



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.

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (<http://www.aetnaretireplans.com>).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) \$4,020

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

Tier 1 - Preferred Generic Generic Drugs	\$10	\$20	\$20
Tier 2 - Generic Generic Drugs	\$20	\$40	\$40
Tier 3 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$45	\$90	\$90



Tier 4 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$95	\$190	\$190
Tier 5 - Specialty Includes high-cost/unique generic and brand drugs	\$95	Limited to one-month supply	Limited to one-month supply

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here’s your cost-sharing for covered Part D drugs after the Initial Coverage limit and until you reach \$6,350 in prescription drug expenses:

Once you reach \$4,020 in drug costs, you pay 25% coinsurance for generic drugs and 25% for brand drugs while in the Coverage Gap phase. Once you reach \$6,350 in out of pocket drug expenses, you qualify for the Catastrophic Coverage phase.

Catastrophic Coverage

Greater of 5% of the cost of the drug - or - \$3.60 for a generic drug or a drug that is treated like a generic and \$8.95 for all other drugs.



Catastrophic Coverage benefits start once \$6,350 in true out-of-pocket costs is incurred.

Requirements:

Precertification	Applies
Step-Therapy	Applies

Non-Part D Drug Rider

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

For more information about Aetna plans, go to www.aetna.com or call Member Services at toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

Not all PPO Plans are available in all areas

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 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.

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).

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. To find a network pharmacy, you can visit our website (<http://www.aetnaretireplans.com>). Quantity limits and restrictions may apply.

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

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.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-888-792-3862, (TTY users should call 711) 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on covered brand name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for



covered generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2020 , that amount is \$6,350 . Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

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 (Non-Part D Drug Rider)

Your Plan Includes a Supplemental Benefit Prescription Drug Rider. Certain types of drugs or categories of drugs are not normally covered by Medicare prescription drug plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. The amount paid when filling a prescription for these drugs does not count towards qualifying for catastrophic coverage. For those receiving Extra Help from Medicare to pay for prescriptions, the Extra Help will not pay for these drugs.

Non-Part D drugs covered under the Supplemental Benefit Prescription Drug Rider are:

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

Below is a list non-Part D drugs that are not covered under the Supplemental Benefit Prescription Drug Rider:

- Non-prescription drugs
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

Non-Part D drugs covered under the rider 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.

You can call Member Services at the number on the back of your Aetna Medicare member ID



card if you have questions.

Plan Disclaimers

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Call 1-888-267-2637 (TTY: 711) for more information.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

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 2020* 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).



CITY OF TAMPA
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Medicare (C05) PPO Plan
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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 www.aetnaretireplans.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).

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

Please contact Customer Service toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

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

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Benefits and Premiums are effective January 1 , 2020 through December 31, 2020

PLAN DESIGN AND BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & Out-of-Network Providers
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Annual Deductible	\$400
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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.

Services exempt from Deductible:

annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, additional Medicare preventive care services, emergency room, emergency ambulance services, urgently needed care.

Annual Maximum Out-of-Pocket Amount	\$3,500
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Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Primary Care Physician Selection	Optional
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There is no requirement for member pre-certification. Your provider will do this on your behalf.

Referral Requirement	None
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PREVENTIVE CARE	This is what you pay for Network & Out-of-Network Providers
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Annual Wellness Exams	\$0
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One exam every 12 months.

Routine Physical Exams	\$0
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Medicare Covered Immunizations	\$0
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Pneumococcal, Flu, Hepatitis B

Routine GYN Care	\$0
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(Cervical and Vaginal Cancer Screenings)



One routine GYN visit and pap smear every 24 months.

Routine Mammograms \$0
(Breast Cancer Screening)

One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.

Routine Prostate Cancer Screening Exam \$0

For covered males age 50 & over, every 12 months.

Routine Colorectal Cancer Screening \$0

For all members age 50 & over.

Routine Bone Mass Measurement \$0

Medicare Diabetes Prevention Program \$0
(MDPP)

12 months of core session for program eligible members with an indication of pre-diabetes.

Routine Eye Exams \$30

One annual exam every 12 months.

Routine Hearing Screening \$0

One exam every 12 months.

Additional Medicare Preventive Services \$0

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease



- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

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 \$30

Outpatient Diagnostic Laboratory \$20

Outpatient Diagnostic X-ray \$20

Outpatient Diagnostic Testing \$20

Outpatient Complex Imaging 10%

Urgently Needed Care; Worldwide \$35

Emergency Care; Worldwide \$50

(waived if admitted)

Ambulance Services \$100

Observation Care

Your cost share for Observation Care is based upon the services you receive.

Inpatient Hospital Care \$250 copay per day, day(s) 1-5

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.



Outpatient Surgery	10%
Blood	All components of blood are covered beginning with the first pint.
<hr/>	
Inpatient Mental Health Care	\$250 copay per day, day(s) 1-5
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	\$30
<hr/>	
Inpatient Substance Abuse	\$250 copay per day, day(s) 1-5
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse	\$30
<hr/>	
Skilled Nursing Facility (SNF) Care	\$0 copay per day, day(s) 1-20; \$75 copay per day, day(s) 21-100
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.	
Home Health Agency Care	\$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	\$30
Cardiac Rehabilitation Services	\$20



Pulmonary Rehabilitation Services	\$30
Radiation Therapy	\$20
Chiropractic Services	\$20
Limited to Original Medicare - covered services for manipulation of the spine.	
Durable Medical Equipment/ Prosthetic Devices	20%
Podiatry Services	\$30
Limited to Original Medicare covered benefits only.	
Diabetic Supplies	\$0
Includes supplies to monitor your blood glucose from LifeScan.	
Diabetic Eye Exams	\$0
Outpatient Dialysis Treatments	\$30
Medicare Part B Prescription Drugs	20%
Medicare Covered Dental	\$30
Non-routine care covered by Medicare.	
Fitness Benefit	
	Silver Sneakers
Hearing Aid Reimbursement	
	\$500 once every 36 months
Resources for Living	
	Covered
For help locating resources for every day needs.	

See next page for Pharmacy-Prescription Drug Benefits.



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.

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (<http://www.aetnaretireplans.com>).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) \$4,020

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

Tier 1 - Generic Generic Drugs	\$15	\$30	\$30
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$25	\$50	\$50



Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$45	\$90	\$90
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	25%	Limited to one-month supply	Limited to one-month supply

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here’s your cost-sharing for covered Part D drugs after the Initial Coverage limit and until you reach \$6,350 in prescription drug expenses:

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage

Greater of 5% of the cost of the drug - or - \$3.60 for a generic drug or a drug that is treated like a generic and \$8.95 for all other drugs.



Catastrophic Coverage benefits start once \$6,350 in true out-of-pocket costs is incurred.

Requirements:

Precertification	Applies
Step-Therapy	Applies

Non-Part D Drug Rider

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

For more information about Aetna plans, go to www.aetna.com or call Member Services at toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

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 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.

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).



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. To find a network pharmacy, you can visit our website (<http://www.aetnaretireplans.com>). Quantity limits and restrictions may apply.

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

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.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-888-792-3862, (TTY users should call 711) 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

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 (Non-Part D Drug Rider)

Your Plan Includes a Supplemental Benefit Prescription Drug Rider. Certain types of drugs or categories of drugs are not normally covered by Medicare prescription drug plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. The amount paid when filling a prescription for these drugs does not count towards qualifying for catastrophic coverage. For those receiving Extra Help from Medicare to pay for prescriptions, the Extra Help will not pay for these drugs.

Non-Part D drugs covered under the Supplemental Benefit Prescription Drug Rider are:

- Agents when used for anorexia, weight loss, or weight gain
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Agents when used for the treatment of sexual or erectile dysfunction (ED)



- Agents when used for the symptomatic relief of cough and colds
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth

Below is a list non-Part D drugs that are **not** covered under the Supplemental Benefit Prescription Drug Rider:

- Non-prescription drugs
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

Non-Part D drugs covered under the rider 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.

You can call Member Services at the number on the back of your Aetna Medicare member ID card if you have questions.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Call 1-888-267-2637 (TTY: 711) for more information.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

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 2020* 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 www.aetnaretireplans.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).

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

Please contact Customer Service toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

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



CITY OF TAMPA
Aetna MedicareSM Plan (PPO)
National Medicare Plan
Custom 15\$/25\$/45\$/25%

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Star treatment

Medicare Star Ratings

Want to know how well your plan rates? Look to the Stars.

Star Ratings are a way for you to compare the relative quality and performance of Medicare Advantage (Part C) and prescription drug (Part D) plans. The Centers for Medicare & Medicaid Services issues the ratings based on:

- Administrative results
- Clinical outcomes
- Plan member surveys

Each plan receives a rating from one star (lowest) to five stars (highest).



How to find your plan's Star Rating

1. Find the state you live in within the chart on the following page.
2. Note the contract number next to the name of your state.
3. Flip to the page in this section with the same contract number in the upper-left corner.
4. Review the medical, drug and overall rating for your plan.

If you have an Aetna Medicare Advantage plan **without** drug coverage, review just the health plan rating. You can ignore the plan's drug rating.

Aetna Medicare Plan (PPO)

State	Contract number
All states	H5521

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Aetna Medicare - H5521

2019 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2019, Aetna Medicare received the following Overall Star Rating from Medicare.

★★★★★
4 Stars

We received the following Summary Star Rating for Aetna Medicare's health/drug plan services:

Health Plan Services: ★★★★★
4 Stars

Drug Plan Services: ★★★★★
4 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time at 833-859-6031 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

Current members please call 800-282-5366 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the number listed in this material.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número de teléfono que se indica en este material.

注意：如果您使用中文，您可以免費獲得語言援助服務。或致電本材料中所列的電話號碼。

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Step by step

What happens next

Let's start your journey off right

Here's a list of documents to look for after you enroll. You'll hear from us within about 30 days of your acceptance into the plan.



Plan confirmation/acceptance letter

This letter includes information to help ensure you understand your plan's features. We'll send it to you once the Centers for Medicare & Medicaid Services approves your enrollment.

You'll get your letter by mail.



Plan member ID card

This card — not your Medicare card — should be used each time you visit the doctor, hospital or pharmacy (if you have prescription drug coverage).

You'll get your member ID card by mail. You'll also find it online.



Evidence of Coverage (EOC)

This is a complete description of coverage under your Medicare plan and your member rights. It's an important document — keep it in a safe place with your other plan information.

You'll get your EOC by mail.



Formulary

This is a list of drugs your plan covers and any special requirements (if you have prescription drug coverage).

You'll get your formulary by mail.

Aetna Medicare is an HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Call **1-800-307-4830 (TTY: 711)** for more information.

Every year, Medicare evaluates plans based on a 5-star rating system.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7 to 14 days. You can call the phone number on your member ID card if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

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.

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.

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.

Important information about your enrollment in a Medicare Advantage plan

As an Aetna Medicare member, you agree to the following:

I will need to keep my Medicare Parts A and B and continue to pay my Part B premium. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform Aetna of any prescription drug coverage that I have or may get in the future.

I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the calendar year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, during the Annual Enrollment Period, which is October 15–December 7 of every year), or under certain special circumstances.

The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that the Aetna Medicare Advantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I am a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare Advantage plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements.

I understand that beginning on the date the Aetna Medicare Advantage plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently

needed services or out-of-area dialysis services. If medically necessary, the Aetna Medicare Advantage plan provides refunds for all covered benefits, even if I get services out of network.

Services authorized by the Aetna Medicare Advantage plan and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with the Aetna Medicare Advantage plan, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan.

Release of information

By joining this Medicare health plan, I acknowledge that the Aetna Medicare Advantage plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Aetna Medicare Advantage plan will release my information, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be disenrolled from the plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, call the phone number listed in this material.

If you believe that Aetna has 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: Aetna Medicare Grievance Department, P.O. Box 14067, Lexington, KY 40512. You can also file a grievance by phone by calling the phone number listed in this material. If you need help filing a grievance, call the phone number listed in this material. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also contact the Aetna Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com, or by writing to Aetna Medicare Grievance Department, ATTN: Civil Rights Coordinator, P.O. Box 14067, Lexington, KY 40512.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

If you speak a language other than English, free language assistance services are available. Visit our website or call the phone number listed in this document. (English)

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. (Spanish)

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。(Traditional Chinese)

Kung hindi Ingles ang wikang inyong sinasalita, may maaari kayong kuning mga libreng serbisyo ng tulong sa wika. Bisitahin ang aming website o tawagan ang numero ng telepono na nakalista sa dokumentong ito. (Tagalog)

Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique gratuits vous sont proposés. Visitez notre site Internet ou appelez le numéro indiqué dans ce document. (French)

Nếu quý vị nói một ngôn ngữ khác với Tiếng Anh, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin vào trang mạng của chúng tôi hoặc gọi số điện thoại ghi trong tài liệu này. (Vietnamese)

Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Besuchen Sie unsere Website oder rufen Sie die Telefonnummer in diesem Dokument an. (German)

영어가 아닌 언어를 쓰시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 저희 웹사이트를 방문하시거나 본 문서에 기재된 전화번호로 연락해 주십시오. (Korean)

Если вы не владеете английским и говорите на другом языке, вам могут предоставить бесплатную языковую помощь. Посетите наш веб-сайт или позвоните по номеру, указанному в данном документе. (Russian)

إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متاحة. تفضل بزيارة موقعنا على الويب أو اتصل برقم الهاتف المدرج في هذا المستند. (Arabic)

अगर आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट पर जाएं या इस दस्तावेज़ में दिए गए फोन नंबर पर कॉल करें। (Hindi)

Nel caso Lei parlasse una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Visiti il nostro sito web oppure chiami il numero di telefono elencato in questo documento. (Italian)

Caso você seja falante de um idioma diferente do inglês, serviços gratuitos de assistência a idiomas estão disponíveis. Acesse nosso site ou ligue para o número de telefone presente neste documento. (Portuguese)

Si ou pale yon lòt lang ki pa Anglè, wap jwenn sèvis asistans pou lang gratis ki disponib. Vizite sitwèb nou an oswa rele nan nimewo telefòn ki make nan dokiman sa a. (Haitian Creole)

Jeżeli nie posługują się Państwo językiem angielskim, dostępne są bezpłatne usługi wsparcia językowego. Proszę odwiedzić naszą witrynę lub zadzwonić pod numer podany w niniejszym dokumencie. (Polish)

英語をお話しにならない方は、無料の言語支援サービスを受けることができます。弊社のウェブサイトアクセスするか、または本書に記載の電話番号にお問い合わせください。(Japanese)

Nëse nuk flisni gjuhën angleze, shërbime ndihmëse gjuhësore pa pagesë janë në dispozicionin tuaj. Vizitoni faqen tonë në internet ose merrni në telefon numrin e telefonit në këtë dokument. (Albanian)

ከእንግሊዘኛ ሌላ ቋንቋ የሚናገሩ ከሆነ ነጻ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይቻላል። የእኛን ድረ-ገጽ ይጎብኙ ወይም በዚህ ሰነድ ላይ የተዘረዘረውን ስልክ ቁጥር በመጠቀም ይደውሉ። (Amharic)

اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، زبان سے متعلق مدد کی مفت خدمات دستیاب ہیں۔ ہماری ویب سائٹ ملاحظہ کریں
یا اس دستاویز میں درج فون نمبر پر کال کریں۔ (Urdu)

אויב איר רעדט א שפראך אויסער ענגליש, זענען שפראך הילף סערוויסעס אוועילעבל. באזוכט אונזער וועבזייטל אדער רופט דעם
טעלעפאן נומער וואס שטייט אויף דעם דאקומענט. (Yiddish)



Here to help

Now that you've reviewed this packet, you know more than you did before about your Medicare choices. But you may still have questions. No problem — we can help.

Just call us at **1-800-307-4830 (TTY:711)**.

We're here 8 a.m. to 6 p.m. local time, Monday through Friday.

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