Information packet

Your guide to getting more out of your plan

Aetna Medicare℠ Plan (PPO)
with Aetna Medicare Rx® Plan

aetna®

www.aetnaretireeplans.com

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Shouldn't your plan give *you* the advantage?

Your health is important to us

We understand you want to make the best choice for your Medicare coverage. That's why each plan we offer is built to help you get more from your Medicare benefits.

We also want you to have a positive health care experience. So let's get started with what matters most.

Your confidence

We're one of the country's largest health insurers. We've been in business for more than 160 years. And we've served Medicare-eligible individuals for more than 50 years.

Your doctors

Our nationwide network of providers makes it easier to see the doctors and hospitals you trust most.

Your prescriptions

Our plans cover many of the most commonly prescribed generic and brand-name drugs. And you can get many of them delivered right to your door with Aetna Rx Home Delivery®.

Your way

Your way begins with choice. Our plans offer you control over how you manage your health care — whether by phone, online, in print or in person.

First things first. Is your doctor covered?

Our online directory has the most up-to-date list of providers in our network.

To find your doctor or hospital, go to **www.aetnaretireeplans.com**.

Once there:

1. Click "Find a doctor, pharmacy or other provider"
2. Choose "Search for doctors, hospitals or other providers"

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.

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Why Aetna Medicare Advantage?

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

- Additional preventive care benefits
- Annual preventive care reminders to get flu shots, important vaccinations and cancer screenings
- Caring support from nurse case managers if you have a chronic or serious health condition
- Access to the National Medical Excellence Program®, a select network of respected doctors and facilities to help you get the right care for a complex illness or injury
- Round-the-clock access to registered nurses through our toll-free Informed Health® Line*

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.

What else you should know

Your acceptance is guaranteed as long as you meet eligibility requirements. You'll also have limits to your out-of-pocket plan costs.

For complete information, be sure to refer to your plan documents.

* 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.

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Why Aetna Medicare Advantage with prescription drug coverage?

Medicare Part D prescription drugs can be expensive. A plan with prescription drug benefits can help you cover the cost.

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 you may pay a lower total premium 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, or drug list:

1. Flip to your plan's benefit summary in the "Plan design and benefits" section
2. Write down the formulary name and the plan's tier structure (for example, 3-tier, 5-tier, etc.) shown under "Pharmacy — Prescription Drug Benefits"
3. Go to **www.aetnaretireeplans.com**
4. Click "Manage your prescription drugs"
5. Choose your formulary name from the "Select your formulary" 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 medications?

If your income is limited, you may qualify for Extra Help to pay for your medicine. This can include:

- Monthly prescription drug premiums
- Annual deductibles
- Copays and coinsurance

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:

- Reached 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.

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A hassle-free pharmacy experience

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

Finding a pharmacy is easy
Just visit **www.aetnaretireeplans.com**. Once there:

1. Click “Find a doctor, pharmacy or other provider”
2. Choose “Find a pharmacy that accepts my plan”
3. Click “Find a pharmacy”
4. Select “Offered by an employer or plan sponsor”

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 Aetna Rx Home Delivery®, 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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Benefits at a glance

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PPO benefits at a glance	Aetna Medicare℠ Plan (PPO)
Hundreds of network doctors or hospitals to choose from	✓
Ability to use providers out of network	✓*
No referrals needed for specialists	✓
Includes all Medicare Parts A and B medical benefits, plus more benefits not covered by Original Medicare	✓
Covers unlimited inpatient hospital days	✓
Offers preventive benefits beyond Original Medicare	✓
Includes special programs to help you manage your health conditions	✓
Covers emergency medical care worldwide	✓
Guarantees acceptance as long as you meet eligibility requirements	✓
No waiting period for pre-existing medical conditions	✓
Includes a secure member website for claim searches	✓
Access to our 24-hour Informed Health® Line**	✓

*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. For a decision about whether we'll cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

**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 aren't a substitute for diagnosis or treatment by a physician or other health care professional.

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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.
Consider an Aetna Medicare Advantage plan with prescription drug coverage if ...	• You want coverage for prescription drugs and medical care • You want a plan that offers: - A network of pharmacies that includes national chains - A formulary — or drug list — that includes most or all Part D drugs - Aetna Rx Home Delivery® for your maintenance drugs - Aetna Specialty Pharmacy® for complex-condition medicines that require special handling, refrigeration, education and support Specialty pharmacies fill high-cost specialty medications that require special handling. Although specialty pharmacies may deliver covered medications through the mail, they aren't considered "mail-order pharmacies." Therefore, most specialty drugs aren't available at the mail-order cost share.

For more information on what your plan offers, see the "Plan design and benefits" section of this packet.

Jot down your notes here

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Plan design and benefits

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Aetna Medicare℠ Plan (PPO) Benefit Summary

The Benefit Summary is an overview of plan benefits. It gives you expected costs for services and describes the benefits package.

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CITY OF TAMPA
Aetna Medicare℠ Plan (PPO)

Medicare (C05) PPO Plan
Custom Rx $10/$20/$45/$95/$95

Benefits and Premiums are effective January 01, 2018 through December 31, 2018

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
Annual Deductible	$400	$700
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 The maximum out-of-pocket limit applies to all covered Medicare Part A and B benefits including deductible.	**Network services:** $3,400	N/A
Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)	N/A	**Network and out-of-network services:** $5,000
Annual Maximum Out-of-pocket Limit amount applies 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
There is no requirement for member pre-certification. Your provider will do this on your behalf.		
Referral Requirement	There is no requirement for member pre-certification. Your provider will do this on your behalf.	

PREVENTIVE CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Annual Wellness Exams One exam every 12 months.	0%	35%
Routine Physical Exams One exam every 12 months.	0%	35%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	0%	0%
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)** One routine GYN visit and pap smear every 24 months.	0%	35%
Routine Mammograms **(Breast Cancer Screening)** One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	0%	35%
Routine Prostate Cancer Screening Exam For covered males age 50 & over, every 12 months.	0%	35%
Routine Colorectal Cancer Screening For all members age 50 & over.	0%	35%
Routine Bone Mass Measurement	0%	35%
Additional Medicare Preventive Services*	0%	35%
Routine Eye Exams One annual exam every 12 months.	0%	35%
Routine Hearing Screening One exam every 12 months.	0%	35%
PHYSICIAN SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Primary Care Physician Visits 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.	$25	35%
Physician Specialist Visits	$50	35%
DIAGNOSTIC PROCEDURES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Outpatient Diagnostic Laboratory	10%	35%

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Outpatient Diagnostic X-ray	10%	35%
Outpatient Diagnostic Testing	10%	35%
Outpatient Complex Imaging	10%	35%
EMERGENCY MEDICAL CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Urgently Needed Care; Worldwide	$50	$50
Emergency Care; Worldwide (waived if admitted)	$65	$65
Ambulance Services	$150	35%
HOSPITAL CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Hospital Care	$200 copay per day, day(s) 1-5	35% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Surgery	20%	35%
Blood	All components of blood are covered beginning with the first pint.	
MENTAL HEALTH SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Mental Health Care	$200 copay per day, day(s) 1-5	35% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care	$40	35%
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Inpatient Substance Abuse (Detox and Rehab)	$200 copay per day, day(s) 1-5	35% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse (Detox and Rehab)	$40	35%

OTHER SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Skilled Nursing Facility (SNF) Care	0% coinsurance, day(s) 1-20; 20% coinsurance, day(s) 21-100	35%
Limited to 100 days per Medicare Benefit Period**. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Home Health Agency Care	0%	35%
Hospice Care	Covered by Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	20%	35%
Cardiac Rehabilitation Services	$50	35%
Pulmonary Rehabilitation Services	$30	35%
Radiation Therapy	20%	35%
Chiropractic Services Limited to Medicare - covered services for manipulation of the spine	20%	35%
Durable Medical Equipment/ Prosthetic Devices	20%	35%
Podiatry Services Limited to Medicare covered benefits only.	$50	35%
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan	0%	35%
Diabetic Eye Exams	0%	35%
Outpatient Dialysis Treatments	20%	20%
Medicare Part B Prescription Drugs	20%	35%
Medicare Covered Dental Non-routine care covered by Medicare	$50	35%
ADDITIONAL NON-MEDICARE COVERED SERVICES		
Hearing Aid Reimbursement	$500 once every 36 months	
Fitness Benefit	Silver Sneakers	

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Resources for Living For help locating resources for every day needs	Covered

PHARMACY - PRESCRIPTION DRUG BENEFITS

Prescription drug calendar year deductible $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.aetnaretireeplans.com).

Formulary 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) $3,750

The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:

5 Tier Plan	Retail cost-sharing (in-network) up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
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†

Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing between the Initial Coverage Limit and until $5,000 in true out-of-pocket costs for Covered Part D drugs are incurred is as follows:

Once you reach $3,750 in drug costs, you pay 44% coinsurance for generic drugs and 35% for brand drugs while in the Coverage Gap phase. Once you reach $5,000 in out of pocket drug expenses, you qualify for the Catastrophic Coverage phase.

Catastrophic Coverage	Greater of $3.35 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $8.35 or 5% for all other covered drugs.

Catastrophic Coverage benefits start once $5,000 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
- 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

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Aetna Medicare℠ Plan (PPO)

Medicare (C05) PPO Plan
Custom Rx $10/$20/$45/$95/$95

* Additional Medicare preventive services include:

- 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

**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.

Not all PPO Plans are available in all areas

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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

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

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

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 benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

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.

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 in-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.

†The Medicare Coverage Gap Discount Program provides a manufacturer discount on brand name drugs to members in a Medicare prescription drug plan. You must have reached the coverage gap and not be receiving Extra Help. The applicable discount is automatically applied by the pharmacy when you are billed for your prescription. A 50 percent discount on the negotiated price (excluding a dispensing fee) is available for brand name drugs from manufacturers that have agreed to pay the discount.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

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).

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

Aetna receives rebates from drug manufacturers that may be considered when determining our preferred drug list. Rebates do not reduce the amount you pay the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available. If you become ill while traveling in the United States, but are outside of your plan's service area, you may need to use an out-of-network pharmacy. An additional cost may be charged for drugs received at an out-of-network pharmacy. 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.

You may get drugs from an out-of-network pharmacy in certain situations, but are limited to a 30-day supply.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24/7
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**
- Your state Medicaid office

If you qualify, Medicare could pay for up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.

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." This plan offers additional coverage for some prescription drugs not normally covered. 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
- 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. The physician can call Aetna for prior authorization, toll free at **1-800-414-2386**.

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

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

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.

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

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Medicare Star Ratings

2018 Medicare plan ratings

Star Ratings are a way for consumers to compare the relative quality of Medicare Advantage plans. The Centers for Medicare & Medicaid Services issues the ratings based on:

- Administrative results
- Clinical outcomes
- Plan member surveys

Every private Medicare Advantage plan receives Star Ratings 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 you 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.

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Aetna Medicare℠ Plan (PPO)

State	Contract number
All states	H5521

Jot down your notes here

Medicare star ratings

(PPO)

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Aetna Medicare - H5521

2017 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 2017, 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:	★★★½ 3.5 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 855-338-7027 (toll-free) or 711 (TTY), from October 1 to February 14. Our hours of operation from February 15 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.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number listed in this material. **ESPAÑOL (SPANISH):** ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en este material.
繁體中文 (CHINESE): 請注意：如果您說中文，您可以獲得免費的語言協助服務。
請造訪我們的網站 www.aetnamedicare.com 或致電本材料中所列的電話號碼。

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Jot down your notes here

What happens next

18.00.130.1 D

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

Material name	Description	Delivery
Plan confirmation/ acceptance letter	We'll send you a letter once the Centers for Medicare & Medicaid Services approves your enrollment. It will include information to help ensure you understand your plan's features.	
Member ID card	Use your plan member ID card — not your Medicare card — each time you visit the doctor, hospital or pharmacy (if you have prescription drug coverage).	
Evidence of Coverage (EOC)	This is a complete description of coverage under your Medicare plan and your member rights. The EOC is an important document. Keep it in a safe place with your other plan information.	or
Formulary	If you have prescription drug coverage, this is a list of drugs your plan covers and any special requirements.	
Health needs assessment	We'll contact you to learn about your health history. Your answers will help us get to know you better and create a health program to fit your needs. The information won't affect your enrollment in the plan.	or
Doctor visit	See your doctor to take advantage of the annual health care services available to you.	

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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/ co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.

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.

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

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

Aetna Medicare's pharmacy network offers limited access to pharmacies with preferred cost sharing in: Suburban NY and Rural UT, AR and NY. 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 pharmacies with preferred cost sharing, members please call the number on your ID card, non-members please call **1-800-307-4830 (TTY: 711)** or consult the online pharmacy directory at **www.aetnaretireeplans.com**.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

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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 enrolment 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, Annual Enrollment Period 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.

Important information about your prescription drug coverage

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

I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I need to keep my Medicare Part A and/or Part B coverage. It is my responsibility to inform the Aetna of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in the Aetna Medicare Rx® (PDP) will end that enrollment. Enrollment in this plan is generally for the calendar year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

The Aetna Medicare Rx (PDP) plan serves a specific service area. If I move out of the area this plan serves, I need to notify the plan and my former employer/union/trust because I may have to disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use those pharmacies. Once I am a member of the Aetna Medicare Rx (PDP) I have the right to appeal plan decisions about payment of benefits or coverage of services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare Rx (PDP) when I get it to know which rules I must follow to get coverage with this Medicare drug plan.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of information

By joining this Medicare prescription drug plan, I acknowledge that the Aetna Medicare Rx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare Rx (PDP) will release my information, including my prescription drug event data, 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.

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