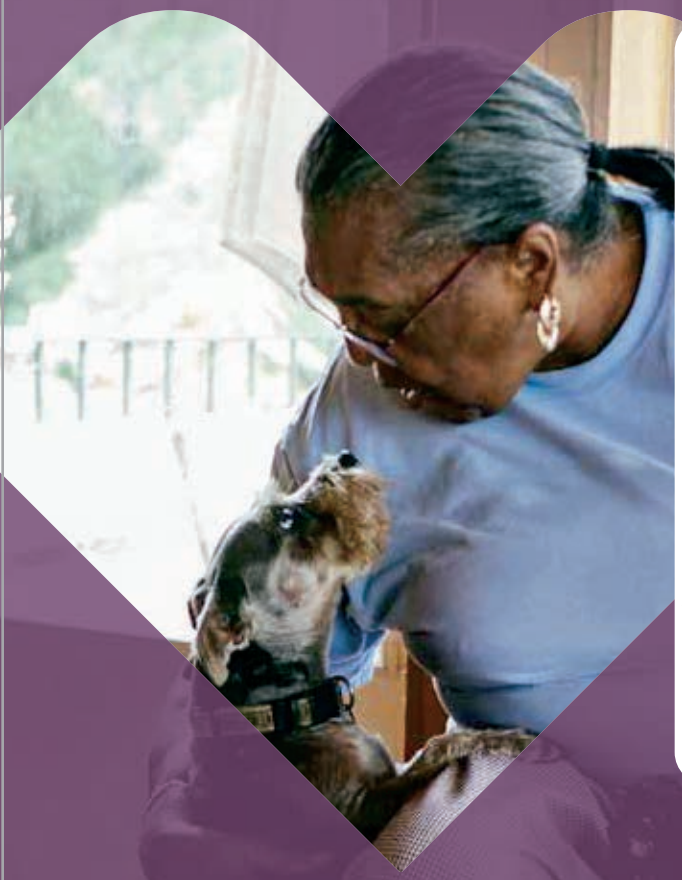

Aetna Medicare® Plan (PPO)
with Extended Service Area (ESA)
and Aetna Medicare Rx® Plan

By your side

Information packet 2021
Your guide to getting more from your plan

58.00.300.1-WELFAREFUND

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aetna™
medicare solutions

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Aetna Medicare® Plan (PPO)
with Extended Service Area (ESA)
and Aetna Medicare Rx® Plan

Hi there

As part of the CVS Health® family, we at Aetna® believe in helping you live your best life, while staying on the path to better health. That's why we deliver a total, connected approach to your health and well-being. So you'll have the confidence to age actively and get the most out of your Medicare plan.

Caring. Convenient. Connected.

Our plans are designed to surround you with the care you need, when you need it. We're available where you live, so you can count on us for support on your health journey.

We're here for you

Have questions along the way? Call us and we'll walk you through it step-by-step.

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151 Farmington Avenue
Hartford, CT 06156

aetna®

Thank you for your interest in Aetna Medicare.

We want you to have a rewarding health care experience. Our plans can help.

This packet contains:

- Information on the benefits, programs and services available to you
- Details to help you better understand the plan features

You'll be automatically enrolled

You don't have to take any action to join the plan. But if you **don't** want to join, just call the Fund Office at **212-247-5225 (TTY: 711)**, between 9 AM and 5 PM ET by November 30, 2020.

Questions?

Just call us at **1-800-307-4830 (TTY: 711)**. We're here 8 AM — 9 PM ET, Monday — Friday.

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Table of contents

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Get the most out of your Medicare plan

You deserve a Medicare plan that focuses on your total health and well-being. We can help you find the coverage that fits your needs. 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 provider search tool** has the most up-to-date list of providers in our network. For **preferred provider organization (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 for going outside the network.

To find a network doctor or hospital, visit aetnaretireeplans.com.

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

Stop by **Medicare.gov** to find a provider in your area that accepts Medicare payment.

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 9 p.m. EST, Monday through Friday.

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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 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, you can enroll in our Medicare Part B-only plan (if offered by your employer, union or trust). 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 get and stay on the path to better health.

Resources For Living® program

Our Resources For Living program helps get you the right support when and where you need it. It's designed to help you find a wide range of services in your area — from personal care, housekeeping and maintenance to caregiver relief, pet care services, and local clubs and social programs.

Healthy Home Visit

A licensed health care professional can come to your home to review your health needs and do a home safety assessment. During the visit, they may also review your medicines, complete some health screening tests if you wish and recommend services that can support your health needs.

24-Hour Nurse Line

You can talk to our registered nurses, day or night. They can help you decide if a doctor or urgent care visit is needed, understand your symptoms or learn about treatments.*

Nurse care management

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

Telehealth services

Can't make it into the doctor's office? You can meet virtually with a primary care physician (PCP) or urgent care center by phone, video or mobile app. You're covered for sick visits, prescription refills and after-hours or weekend care. Check with your PCP or urgent care center to see if they offer telehealth services.

*While only your doctor can diagnose, prescribe or give medical advice, our 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.

TIP

Social health matters

Maybe you've always wanted to make pottery, take a dance class or try your hand at writing. To get you started, our Resources For Living program will help you find a class or activity to fit your interests — and we can even search for transportation options if you need help getting there.

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 Summary of Benefits in the "A closer look" section of this packet
- 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.
- Follow the prescription drug list search instructions for plans offered through an employer or group 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 9 p.m. EST, Monday through Friday.

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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 AM to 7 PM 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.

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 9 p.m. EST, 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℠ Plan (PPO) with ESA
Ability to use any provider at the same cost	✓*
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 preexisting medical conditions	✓
Includes a member website for claim searches	✓

*You can see any provider as long as they are eligible to receive Medicare payments and willing to accept the plan. You'll pay the same cost share all the time, according to the costs listed on your plan benefits summary. 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.

About your plan

Aetna Medicare Plan (PPO) with ESA

A PPO is a preferred provider organization plan. A PPO plan with an extended service area (ESA) gives you the flexibility to see any provider, at the same cost, according to the costs listed on your plan benefits summary. They just have to be eligible to receive Medicare payments and willing to accept your plan.

With a PPO plan with ESA, you'll have the option to choose a primary care physician. When we know who your doctor is, we can direct you to programs and services that support your doctor's care and help you reach your best health.

Does your doctor accept our plans? Chances are they may. Call us or visit **Medicare.gov** to find a doctor or hospital in your area.

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

TIP

Get checked out

Your Aetna plan helps you stay on track
by covering preventive care.
This includes a wellness exam,
screenings, vaccines and more.

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A closer look

Summary of Benefits
Aetna Medicare Plan (PPO)

Aetna Medicare Plan (PPO)

The Summary of Benefits shows 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, 2021 through December 31, 2021

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & out-of-network providers
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	$6,700
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.	
HOSPITAL CARE	**This is what you pay for Network & out-of-network providers**
Inpatient Hospital Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay. Prior authorization or physician's order may be required.	
Outpatient Hospital Care	$0
Prior authorization or physician's order may be required.	
PHYSICIAN SERVICES	**This is what you pay for network & out-of-network providers**
Primary Care Physician Visits	$20
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	$20
Primary Care Physician Selection	Optional

There is no requirement for member pre-certification. Your provider will do this on your behalf.

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

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network & out-of-network providers
Emergency Care; Worldwide (waived if admitted)	$90
Urgently Needed Care; Worldwide	$20
DIAGNOSTIC PROCEDURES	**This is what you pay for network & out-of-network providers**
Outpatient Diagnostic Laboratory	$20
Prior authorization or physician's order may be required.	
Outpatient Diagnostic X-ray	$20
Prior authorization or physician's order may be required.	
Outpatient Diagnostic Testing	$20
Prior authorization or physician's order may be required.	
Outpatient Complex Imaging	$20
Prior authorization or physician's order may be required.	
HEARING SERVICES	**This is what you pay for network & out-of-network providers**

Routine Hearing Screening One exam every 12 months.	$0
Hearing Aid Reimbursement Applies to in or out of network	$3,000 once every 36 months
DENTAL SERVICES	**This is what you pay for network & out-of-network providers**
Medicare Covered Dental Non-routine care covered by Medicare. Prior authorization or physician's order may be required.	$20
VISION SERVICES	**This is what you pay for network & out-of-network providers**
Routine Eye Exams One annual exam every 12 months.	$0
Diabetic Eye Exams	$0
MENTAL HEALTH SERVICES	**This is what you pay for network & out-of-network providers**
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay. Prior authorization or physician's order may be required.	$250 per stay
Outpatient Mental Health Care Prior authorization or physician's order may be required.	$20
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay. Prior authorization or physician's order may be required.	$250 per stay
Outpatient Substance Abuse Prior authorization or physician's order may be required.	$20
SKILLED NURSING SERVICES	**This is what you pay for Network & out-of-network providers**
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. Prior authorization or physician's order may be required.

*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.

PHYSICAL THERAPY SERVICES	This is what you pay for network & out-of-network providers
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy) Prior authorization or physician's order may be required.	$20

AMBULANCE SERVICES	This is what you pay for network & out-of-network providers
Ambulance Services Prior authorization or physician's order may be required.	$20

TRANSPORTATION SERVICES	This is what you pay for network & out-of-network providers
Transportation (non-emergency)	24 trips with 60 miles allowed per trip

MEDICARE PART B DRUGS	This is what you pay for network & out-of-network providers
Medicare Part B Prescription Drugs	$0

ADDITIONAL SERVICES	This is what you pay for network & out-of-network providers
Blood Covered in and out of network	All components of blood are covered beginning with the first pint.
Observation Care Covered in and out of network	Your cost share for Observation Care is based upon the services you receive.
Outpatient Surgery Prior authorization or physician's order may be required.	$0

Home Health Agency Care	$0
Prior authorization or physician's order may be required.	
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Cardiac Rehabilitation Services	$20
Pulmonary Rehabilitation Services	$20
Radiation Therapy	$20
Chiropractic Services	$15
Limited to Original Medicare - covered services for manipulation of the spine. Prior authorization or physician's order may be required.	
Durable Medical Equipment/ Prosthetic Devices	20%
Prior authorization or physician's order may be required.	
Podiatry Services	$20
Limited to Original Medicare covered benefits only.	
Diabetic Supplies	$0
Includes supplies to monitor your blood glucose.	
Outpatient Dialysis Treatments	$20
Prior authorization or physician's order may be required.	
ADDITIONAL NON-MEDICARE COVERED SERVICES	**This is what you pay for network & out-of-network providers**
Meals	Covered up to 14 meals following an inpatient stay.
Prior authorization or physician's order may be required.	
Resources For Living®	Covered
For help locating resources for every day needs.	
Telehealth	Covered
Telemedicine Services. Telehealth services covered when provided by PCP, Behavioral Health or Urgent Care providers. Member cost share will apply based on services rendered.	
Acupuncture	$20

Covered in lieu of anesthesia or relief of chronic pain	
Enhanced Chiropractic Services Unlimited visits per year.	$15

See next page for Pharmacy-Prescription Drug Benefits.

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.aetnaretireeplans.com).

Formulary (Drug List) GRP B2 Plus

Initial Coverage Limit (ICL) $4,130

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):

3 Tier Plan	Retail cost sharing 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 - Generic Generic Drugs	$5	$10	$10
Tier 2 - Preferred Brand Preferred Brand Drugs	$25	$50	$50
Tier 3 - Non-Preferred Brand Non-Preferred Brand Drugs	$35	$70	$70

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 $6,550 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:	Your share of the cost for a covered drug will be 5% but not greater than the cost share amounts listed in the Initial Coverage Stage section above.

Catastrophic Coverage benefits start once $6,550 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Applies

Enhanced Drug Benefit

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

- $0 cost share for certain covered oral contraceptives
- $0 cost share for covered drugs used for smoking cessation
- $0 cost share for insulin on the Preferred Brand tier

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). Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

Medical Disclaimers

The provider network may change at any time. You will receive notice when necessary.

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 complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

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.

Pharmacy Disclaimers

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).

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

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.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

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.

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.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. 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.

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 for some drugs not typically covered by a Medicare Part D plan. Refer to the "Enhanced Drug Benefit" section in the chart above. Non-Part D drugs covered under the enhanced drug benefit 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.

Plan Disclaimers

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

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

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 2021* 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.aetnaretireeplans.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.

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

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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 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.

Aetna Medicare Plan (PPO)

State	Contract number
Alabama	H5521
Arizona	H5521
Arkansas	H1608
California	H5521
Colorado	H5521
Connecticut	H5521
Delaware	H5521
District of Columbia	H5521
Florida	H5521
Georgia	H1608, H3288, H5521
Illinois	H1608, H5521
Indiana	H5521
Iowa	H1608
Kansas	H1608
Kentucky	H5521
Louisiana	H5521
Maine	H5521
Massachusetts	H5521
Michigan	H5521
Mississippi	H5521
Missouri	H1608
Nebraska	H1608
Nevada	H5521
New Jersey	H5521
New York	H5521
North Carolina	H5521
Ohio	H1608, H5521
Oklahoma	H1608, H3288
Pennsylvania	H5521, 5522
South Carolina	H5521
South Dakota	H1608
Tennessee	H5521
Texas	H3288
Utah	H5521
Virginia	H5521
Washington	H5521
West Virginia	H1608
Wisconsin	H5521
Wyoming	H5521

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2020 Star Ratings

Aetna Medicare - H1608
2020 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 2020, Aetna Medicare received the following Overall Star Rating from Medicare.

★★★½
3.5 Stars

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

	★★★
Health Plan Services:	3 Stars
	★★★★½
Drug Plan Services:	4.5 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 6:00 p.m. Local time at 800-307-4830 (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 6:00 p.m. Local time.

Current members please call 888-267-2637 (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.

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

Y0001_2020_1090_H1608RV1_M

2020 Star Ratings

Aetna Medicare - H3288
2020 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 2020, Aetna Medicare received the following Overall Star Rating from Medicare.

Plan too new to be measured

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

Health Plan Services:	Plan too new to be measured
Drug Plan Services:	Plan too new to be measured

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 6:00 p.m. Local time at 800-307-4830 (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 6:00 p.m. Local time.

Current members please call 888-267-2637 (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 HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Y0001_2020_1090_H3288RV1_M

2020 Star Ratings

Aetna Medicare - H5521
2020 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 2020, Aetna Medicare received the following Overall Star Rating from Medicare.

★★★★½
4.5 Stars

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

Health Plan Services:	★★★★½ 4.5 Stars
Drug Plan Services:	★★★★½ 4.5 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 6:00 p.m. Local time at 800-307-4830 (toll-free) or 771 (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 6:00 p.m. Local time.

Current members please call 888-267-2637 (toll-free) or 771 (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 HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Y0001_2020_1090_H5521RV2_M

2020 Star Ratings

Aetna Medicare - H5522
2020 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 2020, Aetna Medicare received the following Overall Star Rating from Medicare.


4.5 Stars

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

	
Health Plan Services:	4.5 Stars
	
Drug Plan Services:	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 6:00 p.m. Local time at 800-307-4830 (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 6:00 p.m. Local time.

Current members please call 888-267-2637 (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 HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Y0001_2020_1090_H5522RV1_M

2020 Star Ratings

Aetna Medicare - H7301
2020 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 2020, Aetna Medicare received the following Overall Star Rating from Medicare.

★★★★½
4.5 Stars

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

	★★★★
Health Plan Services:	4 Stars
	★★★★★
Drug Plan Services:	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 6:00 p.m. Local time at 800-307-4830 (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 6:00 p.m. Local time.

Current members please call 888-267-2637 (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 HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Y0001_2020_1090_H7301RV1_M

18.00.130.1_A

Step-by-step

What happens next?

Start your journey off right

Below is a list of things to look for after you're enrolled. You'll hear from us within about 30 days of your acceptance into the plan.

Plan confirmation and 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.

You'll find your EOC online.

Formulary

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

You'll find your formulary online.

Schedule of Cost Sharing (SOC)

This is the share of costs covered by Aetna that you pay out of your own pocket. This can include deductibles, coinsurance, copayments or similar charges.

You'll get your SOC by mail.

Healthy Home Visit

Expect a call from Aetna to schedule a Healthy Home Visit. You'll get in-home advice from a licensed health care professional on how to reach your health goals.

Aetna Medicare is a 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 10 days. You can call **1-888-267-2637 (TTY: 711)**, 8 AM to 9 PM ET, Monday through Friday, 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.

Aetna Medicare's pharmacy network includes limited lower cost preferred pharmacies in: rural Nebraska, rural Kansas, suburban West Virginia, rural Maine, suburban Arizona, rural Michigan, urban Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call **1-855-338-7027 (TTY: 711)** or consult the online pharmacy directory at **AetnaMedicare.com/pharmacyhelp**.

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.

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

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.

18.28.328.1_A

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.

18.32.301.1-C3_A

Here for you

We’re here to help answer your questions, so you can feel confident about your Medicare coverage. Check out the helpful resources on the next page.

Helpful resources

Keep these helpful resources handy, so you can refer back to them at any time. Simply tear out this page and put it somewhere you'll see every day.

Give us a ring

Call us at 1-800-307-4830 (TTY: 711).
We're available 8 a.m. to 9 p.m. EST, Monday through Friday.

Websites to remember

Want more information about the plan and additional wellness programs? Looking for a doctor or hospital?

Visit aetnaretireeplans.com.
to find all that and more.

Visit **Medicare.gov** for more information about how Medicare works.

18.39.303.1_A (8/20)

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