



Benefits and Premiums are effective January 1, 2016 through  
 December 31, 2016

National

PLAN DESIGN AND BENEFITS  
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
<b>Combined In and Out of Network Deductible (Plan Level/includes Network Deductible)</b>	\$0	\$0
<b>Member Coinsurance</b> Applies to all expenses unless otherwise stated.	N/A	30%
<b>Annual Maximum Out-of-Pocket Amount (includes deductible)</b>	\$6,700	N/A
<b>Combined Annual Maximum Out-of-Pocket Amount (Plan Level / includes deductible)</b> 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.	N/A	\$10,000
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certification is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.		
<b>Referral Requirement</b>	None	None
PREVENTIVE CARE	Network Providers	Out-of-Network Providers
<b>Annual Wellness Exams</b> One exam every 12 months.	Covered 100%	30%
<b>Routine Physical Exams</b> One exam every 12 months.	Covered 100%	30%
<b>Medicare Covered Immunizations</b> Pneumococcal, Flu, Hepatitis B	Covered 100%	Covered 100%
<b>Routine GYN Care (Cervical and Vaginal Cancer Screenings)</b> One routine GYN visit and pap smear every 24 months.	Covered 100%	30%
<b>Routine Mammograms (Breast Cancer Screening)</b> One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over.	Covered 100%	30%



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<b>Routine Prostate Cancer Screening Exam</b>	Covered 100%	30%
For covered males age 50 and over every 12 months.		
<b>Routine Colorectal Cancer Screening</b>	Covered 100%	30%
For all members age 50 and over.		
<b>Routine Bone Mass Measurement</b>	Covered 100%	30%
One exam every 24 months.		
<b>Additional Medicare Preventive Services***</b>	Covered 100%	30%
<b>Routine Eye Exams</b>	Covered 100%	30%
One annual exam every 12 months.		
<b>Routine Hearing Screening</b>	Covered 100%	30%
One exam every 12 months.		
<b>PHYSICIAN SERVICES</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Primary Care Physician Visits</b>	\$30 copay	30%
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.		
<b>Physician Specialist Visits</b>	\$30 copay	30%
<b>Allergy Testing</b>	\$30 copay	30%
<b>DIAGNOSTIC PROCEDURES</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Outpatient Diagnostic Laboratory</b>	\$30 copay	30%
<b>Outpatient Diagnostic X-ray</b>	\$30 copay	30%
<b>Outpatient Diagnostic Testing</b>	\$30 copay	30%
<b>Outpatient Complex Imaging</b>	\$30 copay	30%
<b>EMERGENCY MEDICAL CARE</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Urgently Needed Care; Worldwide</b>	\$30 copay	\$30 copay
<b>Emergency Care; Worldwide (waived if admitted)</b>	\$65 copay	\$65 copay
<b>Ambulance Services</b>	\$30 copay	30%



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<b>HOSPITAL CARE</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Inpatient Hospital Care</b>	\$500 per stay	30% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Surgery</b>	\$120 copay	30%
<b>MENTAL HEALTH SERVICES</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Inpatient Mental Health Care</b>	\$500 per stay	30% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Mental Health Care</b>	\$30 copay	30%
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Inpatient Substance Abuse (Detox and Rehab)</b>	\$500 per stay	30% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Substance Abuse (Detox and Rehab)</b>	\$30 copay	30%
<b>OTHER SERVICES</b>	<b>Network Providers</b>	<b>Out-of-Network Providers</b>
<b>Skilled Nursing Facility (SNF) Care</b>	\$0 per day copay, day(s) 1-20, \$50 per day copay, day(s) 21-100	30%
Limited to 100 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
<b>Home Health Agency Care</b>	Covered 100%	30%
<b>Hospice Care</b>	Covered by Medicare at a Medicare certified hospice.	
<b>Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)</b>	\$30 copay	30%
<b>Cardiac Rehabilitation Services</b>	\$30 copay	30%
<b>Chiropractic Services</b>	\$20 copay	30%
For manipulation of the spine to the extent covered by Medicare.		
<b>Durable Medical Equipment/ Prosthetic Devices</b>	20%	30%
<b>Podiatry Services</b>	\$30 copay	30%
Limited to Medicare covered benefits only.		
<b>Diabetic Supplies</b>	Covered 100%	30%
<b>Outpatient Dialysis Treatments</b>	\$30 copay	\$30 copay
<b>Medicare Part B Prescription Drugs</b>	Covered 100%	30%
<b>Allergy Injections</b>	Covered 100%	30%
<b>ADDITIONAL NON-MEDICARE COVERED SERVICES</b>		
<b>Healthy Lifestyle Coaching</b>		Covered
One phone call per week.		
<b>Vision Eyewear Reimbursement</b>	\$70 reimbursement every 24 months	
<b>Hearing Aid Reimbursement</b>	\$500 Once Every 36 Months	



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**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

**Formulary** GRP B2 (Three Tier)

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. Refer to the "Coverage Tier Chart" below to find which drug types are included in each tier of your plan design.

**Initial Coverage Limit (ICL)** \$3,310 Covered Medicare Prescription Drug Expenditure

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:

**Standard Retail - Member Cost-Sharing up to the Initial Coverage Limit**

- Member pays \$10 for Tier 1 Generic
- Member pays \$25 for Tier 2 Preferred Brand (includes some high-cost generic and preferred generic and non-preferred brand drugs)
- Member pays \$45 for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs)

Up to one month (30) supply at indicated copay or coinsurance  
 Three month (90) supply available at retail. When you obtain a 90 day supply at retail, you pay your Preferred Mail Order cost share.



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<b>Preferred Mail Order through Aetna Rx Home Delivery - Member Cost-Sharing up to Initial Coverage Limit</b>	Member pays \$30 for Tier 1 Generic Member pays \$75 for Tier 2 Preferred Brand (includes some high-cost generic and preferred generic and non-preferred brand drugs) Member pays \$135 for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs)
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Up to a three month (90) supply available via our preferred vendor, Aetna Rx Home Delivery.

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**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 \$4,850 in true out-of-pocket costs for Covered Part D drugs is incurred is as follows:

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<b>Standard Retail - Member Cost-Sharing during Coverage Gap**</b>	Member pays \$10 for Tier 1 Generic Member pays \$25 for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays \$45 for Tier 3 Non-Preferred Brand (includes some high-cost non-preferred generic and non-preferred brand drugs)
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Up to one month (30 days) supply at indicated copay or coinsurance  
 Three month (90 days) supply available at retail. When you obtain a 90 day supply at a standard retail pharmacy, you pay your Preferred Mail Order cost share.

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<b>Preferred Mail Order through Aetna Rx Home Delivery - Member Cost Sharing during Coverage Gap**</b>	Member pays \$30 for Tier 1 Generic Member pays \$75 for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays \$135 for Tier 3 Non-Preferred Brand (includes some high-cost non-preferred generic and non-preferred brand drugs)
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Up to a three month (90) supply available via our preferred vendor, Aetna Rx Home Delivery.

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<b>Catastrophic Coverage</b>	Greater of \$2.95 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of \$7.40 or 5% for all other covered drugs
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Catastrophic Coverage benefits start once \$4,850 in true out-of-pocket costs is incurred.

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<b>Requirements:</b>	
<b>Precertification</b>	Applies
<b>Step-Therapy</b>	Applies
<b>Non-Part D Drug Rider</b>	Not Covered

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**Coverage Tier Chart**

Tier 1 Generic: includes low-cost generic drugs

Tier 2 Preferred Brand: includes some high-cost generic and preferred brand drugs

Tier 3 Non-Preferred Brand: includes some high-cost non-preferred generic and non-preferred brand drugs

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\*\*\* 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

**Aetna Medicare is a Medicare Advantage organization with a Medicare contract. Enrollment in Aetna Medicare depends on contract renewal.**

**The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium, and/or copayments/coinsurance 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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You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

This material is for informational purposes only and is not medical advice. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Contact a health care professional with any questions or concerns about specific health care needs. See your Evidence of Coverage for a complete description of benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by location and are subject to change. 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. Aetna is not a provider of health care services and, therefore, cannot guarantee any results or outcomes. Provider participation may change without notice. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. For more information about Aetna plans, go to [www.aetna.com](http://www.aetna.com).

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.

\*Your plan sponsor or former employer provides additional coverage during the coverage gap phase for covered brand name drugs. This means that you will generally continue to pay the same amount for covered brand name drugs throughout the coverage gap phase of the plan as you paid in the initial coverage phase.





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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 offering 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
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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.

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.

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

This information is available for free in other languages. Please call our customer service number at **1-888-982-3862 (TTY: 711)** for additional information. Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-888-982-3862 (TTY: 711)**. Horario de atención: de Lunes a Viernes, de 8 a.m. a 6 p.m.

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](http://www.aetna.com).

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