Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Enrollment packet

CITY OF Marietta GEORGIA

Your guide to getting more out of your plan

Visit
http://aetnaretireeplans.com

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

58.00.300.1-MARIETTA

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151 Farmington Avenue, F265
Hartford, CT 06156

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Thank you for your interest in Aetna Medicare

We want you to have a positive health care experience. Our plans can help you.
This enrollment packet contains:

- Information that describes the benefits, programs and services available to you
- Details to help you better understand the features of this plan
- Everything you need to enroll today

How to get started

- Review the plan benefits in this enrollment packet.
- Review the information included in this packet, along with your Annual Notification of Change/Evidence of Coverage document for more details about your plan.
- We will automatically re-enroll you in your current plan. No action is needed.
- If you no longer want your current plan, call us and we will remove you.
- Follow any instructions from your former employer/union or trust, as applicable.

We're here to help. Call us if you have questions.

Questions?

Call us:

1-800-307-4830 (TTY:711)

We're available 8 a.m. – 6 p.m. local time, Monday to Friday.

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Jot down your notes here

Shouldn't your plan give YOU the advantage?

Your health is important. We know there are few things more crucial than making the best choice for your Medicare coverage.

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

Your confidence

We've been in business for more than 150 years. We've served Medicare-eligible individuals for more than 40 years.

Your doctors

Is your doctor covered? We have a large, nationwide network of doctors and hospitals. And finding your doctor (or a new doctor in your area) is easy. Just go to **http://www.aetnamedicare.com**. If you don't see your doctor listed, call **1-800-307-4830 (TTY: 711)** 8 a.m. – 6 p.m. local time, Monday through Friday.

Your prescriptions

Are your drugs covered? We offer an all-in-one plan that combines prescription drug coverage and medical benefits. This plan may actually lower what you pay each month. To view a list of drugs (also called a formulary), jot down the name of the formulary included with this plan. You'll find that in the Plan design and benefits section of this booklet. Next, go to **http://www.aetnaretireeplans.com**, click "Manage your prescription drugs" then "Select your formulary." If you don't see your drugs on the list, call us at **1-800-307-4830 (TTY: 711)** 8 a.m. – 6 p.m. local time, Monday through Friday.

Your savings

How much will you have to pay for services? The government helps us pay for medical services for our Medicare Advantage members. This help lets us offer you greater benefits at less cost. Check out your plan design and benefits in this packet.

Your way

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

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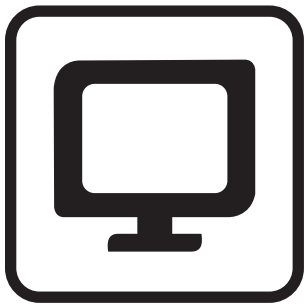

First things first. Is your doctor covered?

We believe a healthier experience begins with what matters most to you. And we have helpful tools, like our online provider directory, to help you find your doctor or hospital.

◀ Visit **http://www.aetnamedicare.com** to find the doctors and hospitals you trust most.

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Why Aetna Medicare Advantage?

What's special?

We offer disease management programs. They help you manage health conditions such as hypertension (high blood pressure) and diabetes.

The plan also offers:

- Access to the National Medical Excellence Program,® a select network of respected doctors and facilities to help those with a complex illness or injury get the appropriate care
- Preventive benefits not covered under Medicare
- Annual preventive care reminders to get flu shots, important vaccinations and cancer screenings
- Caring support from our nurse case managers for those with chronic or serious health conditions
- Round-the-clock access to registered nurses through our toll-free Informed Health® Line*

What you should know

You must be entitled to Medicare Part A, enrolled in Medicare Part B and continue to pay your Part A and Part B premiums, if applicable. You must also live in the plan's service area. If you don't have Medicare Part A, you should contact your employer/union/trust and ask about our Medicare PPO plan Part B only.

You'll also be glad to know:

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

For complete information, please refer to your plan documents.

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*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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Benefits at a glance

Benefits at a glance	Aetna Medicare Plan (PPO) with an ESA
Hundreds of network doctors or hospitals to choose from	✓
Ability to use providers out of network at the same cost sharing	✓*
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**	✓

*You can see any provider in and out of network. If you choose to see an out-of-network provider, they must be eligible to receive Medicare payments and willing to accept the plan. You'll pay the in-network cost share all the time. 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.

**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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About your plan

Your Aetna Medicare preferred provider organization (PPO) with extended service area (ESA) plan	• Gives you flexibility to see doctors and hospitals both in and out of our network at the same cost. • Provides services and programs beyond Original Medicare. You can see any provider eligible to receive Medicare payments and willing to accept the plan. You can visit **http://www.aetnamedicare.com** or **http://www.medicare.gov** to find a doctor or hospital in your area.
When to consider an Aetna Medicare PPO with ESA, plus prescription drug coverage	• You want to get coverage for prescription drugs and medical care. You may pay a lower total premium for this type of all-in-one plan. • You want a plan with access to: - A network of pharmacies that includes national chains - A prescription drug formulary that covers most Part D drugs depending upon the formulary your plan selects - A mail-order prescription drug program for maintenance drugs, with prescriptions conveniently delivered to your home, doctor's office or anywhere you prefer - A specialty pharmacy for medications to treat complex conditions and to handle drugs that need special care, such as refrigeration - Medication that's securely packed, mailed quickly and safely, and checked for accuracy - Pharmacy help over the phone - Member education and support

For more information on what each plan offers, see the plan design and benefits section in this packet.

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Plan design and benefits

Aetna Medicare℠ Plan (PPO) Benefit Summary

This summary gives you an overview of plan benefits. It gives you expected costs for services and describes the benefits package.

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Benefits and Premiums are effective January 01, 2017 through December 31, 2017

PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & Out-of-Network Providers
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	$2,400
The maximum out-of-pocket limit applies to all covered Medicare Part A and B benefits including deductible.	
Primary Care Physician Selection	Optional
There is no requirement for member pre-certification. Your provider will do this on your	
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)**	$0
One routine GYN visit and pap smear every 24 months.	
Routine Mammograms **(Breast Cancer Screening)**	$0
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	
Routine Prostate Cancer Screening Exam	$0
For covered males age 50 & over, every 12 months.	
Routine Colorectal Cancer Screening For all members age 50 & over.	$0
Routine Bone Mass Measurement	$0

Additional Medicare Preventive Services*	$0
Diabetic Eye Exams	$0
Routine Eye Exams One annual exam every 12 months.	$0
Routine Hearing Screening One exam every 12 months.	$0
PHYSICIAN SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Primary Care Physician Visits	$5
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	$10
DIAGNOSTIC PROCEDURES	**This is what you pay for Network & Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$10
Outpatient Diagnostic X-ray	$10
Outpatient Diagnostic Testing	$10
Outpatient Complex Imaging	$25
EMERGENCY MEDICAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Urgently Needed Care; Worldwide	$35
Emergency Care; Worldwide (waived if admitted)	$65
Ambulance Services	$100
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.	
Outpatient Surgery	$100
MENTAL HEALTH SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Mental Health Care	$250 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$10
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Substance Abuse (Detox and Rehab)	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse (Detox and Rehab)	$10
OTHER 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.	
Home Health Agency Care	$0
Hospice Care	Covered by Medicare at a Medicare certified hospice.
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$10
Cardiac Rehabilitation Services	$10
Pulmonary Rehabilitation Services	$10
Radiation Therapy	$25
Chiropractic Services	$10
Limited to Medicare - covered services for manipulation of the spine	
Durable Medical Equipment/ Prosthetic Devices	$0
Podiatry Services	$10
Limited to Medicare covered benefits only.	
Diabetic Supplies Includes supplies to monitor your blood glucose	$0
Outpatient Dialysis Treatments	20%
Medicare Part B Prescription Drugs	$0

ADDITIONAL NON-MEDICARE COVERED SERVICES	
Healthy Lifestyle Coaching One phone call per week.	Covered
Fitness Benefit	Silver Sneakers

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)	$3,700

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:

4 Tier with Specialty 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 - Generic Generic Drugs	$10	$20	$20

4 Tier with Specialty 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 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$25	$50	$50
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$40	$80	$80
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	$40	$80	$80

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 $4,950 in true out-of-pocket costs for Covered Part D drugs are incurred is as follows:

Your plan sponsor/former employer provides additional coverage during the Coverage Gap stage. 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. Once you reach $4,950 in out of pocket drug expenses, you qualify for the Catastrophic Coverage phase.

Catastrophic Coverage	Greater of $3.30 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $8.25 or 5% for all other covered drugs.
Catastrophic Coverage benefits start once $4,950 in true out-of-pocket costs is incurred.	
Requirements:	
Precertification	Applies
Step-Therapy	Applies
Non-Part D Drug Rider	
	• Agents when used for anorexia, weight loss, or weight gain • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations • Agents when used for the treatment of sexual or erectile dysfunction (ED) • Agents when used for the symptomatic relief of cough and colds • Agents used to promote fertility • Agents used for cosmetic purposes or hair growth

* 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.

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

†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.

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 preparations
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Agents when used for the symptomatic relief of cough and colds
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth

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

- Non-prescription drugs

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

Non-Part D drugs covered under the rider can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan. 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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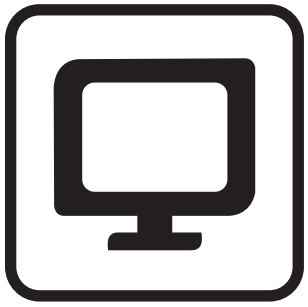
Jot down your notes here

Aetna Medicare with prescription drug coverage



First things first. Are my prescription drugs covered?

Visit **http://www.aetnaretireeplans.com** to view our drug list (also called the formulary). You'll need to know the name of the formulary included with this plan. Check the ***Plan design and benefits*** section for that name. If you don't see your drug on the list, call us at **1-800-307-4830 (TTY: 711)**, 8 a.m. – 6 p.m. local time, Monday through Friday.

Having trouble paying for your medications?

Those with limited incomes may qualify for Extra Help that pays for their medicine. This can include:

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

You can find out if you qualify:

- 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.
- Or contact your state Medicaid office.

Why Aetna Medicare with prescription drug coverage?

The Aetna Medicare with Prescription Drug Plan (PDP) combines a Medicare Advantage medical plan with prescription drug coverage. So you need only one plan and one ID card for all your medical and prescription drug needs.

The plan covers a wide range of top generic and brand-name Part D medications. It also covers many hard-to-find medications such as self-injectables.

And it can help you cover the cost of Part D prescription drugs, which can be a large expense.

Save money on drug costs

The Medicare Coverage Gap Discount Program gives manufacturer discounts on brand-name drugs to Part D enrollees 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 networks offer access to national chain pharmacies. You'll have local options for your drugs. You can also use our mail-order service. They'll deliver many drugs right to your home. Standard delivery is free.

For a full list of our network pharmacies and locations, call **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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Medicare star ratings

2016 Medicare Plan 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 this plan rating to compare our plan's performance to other plans. Examples of the areas covered by this rating 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

How to find the Medicare Star Rating for your plan

You can find the rating that applies to your plan by using the chart below. Each plan has a contract number that identifies the plan with the Centers for Medicare & Medicaid Services (CMS).

1. Find the state you live in below. The contract number assigned to your state will be the number you look for when searching the Star Ratings included in this packet. It will be in the upper left corner of the page.
2. Then go to the following pages and search for that contract number.
3. Look for the rating for medical, drug and an overall rating listed for each plan.
4. If you only have a Medicare Advantage (MA) plan, please ignore the drug rating. Refer to the health plan rating only.

We're here to help

If you have any questions, call the number shown in this packet for dedicated service specific to your plan.

You can also call the number on the Star Rating page for general member services. They can help, but for quicker and easier service, use the number in this booklet.

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Aetna Medicare℠ PPO Plan

State	Contract number
All states	H5521

Aetna Medicare℠ HMO Plan

State	Contract number
Arizona	H3931
California	H0523
Colorado	H3931
Connecticut	H5793
Delaware	H3931
District of Columbia	H3931
Florida	H5414
Georgia	H1109
Illinois	H3931
Kansas	H3931
Kentucky	H3931
Maine	H3597
Maryland	H3931
Massachusetts	H3931
Missouri	H3931
Nevada	H3931
New Jersey	H3152
New York	H3312
North Carolina	H3931
Ohio	H3931
Oklahoma	H3931
Pennsylvania	H3931
Tennessee	H3931
Texas	H4523
Virginia	H3931
West Virginia	H3931

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Coverage is provided through a Medicare Advantage organization or a Medicare prescription drug plan sponsor with a Medicare contract. Benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

Medicare star ratings

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Aetna Medicare - H5521

2016 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 2016, 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:	★★★★★ 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 15 to December 7. Our hours of operation for the rest of the year 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).

Y0001_2016_1009_5521v3 accepted 10/2015

*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.

Jot down your notes here

What happens next

After you enroll, you can use this checklist to keep track of your new plan. 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.	
Member ID card	Use your Aetna member ID card (not your Medicare card) every time you visit the doctor, hospital or pharmacy (if you have prescription drug coverage).	
Evidence of Coverage (EOC) and drug formulary	The EOC is a complete description of coverage under your Aetna Medicare plan. It includes your rights as a member. If you have prescription drug coverage, the formulary is a list of covered drugs and special requirements.	 or 
Owner's manual	You'll find helpful tools, cost-saving resources and important tips. Think of it as your quick guide to getting the most out of your plan.	
Health needs assessment	We'll contact you to learn about your health history. The information will not affect your enrollment in the plan.	 or 
Doctor visit	See your doctor to take advantage of the annual health care services available to you.	

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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. 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. 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, provider network, premium and/or copayments/coinsurance may change on January 1 of each year.

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 7-10 days. You can call **1-888-792-3862 (TTY: 711)**, 24 hours a day, 7 days a week, if you do not receive your mail-order drugs within this time frame. 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 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 ME, NY, UT and WY. 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 **1-855-338-7027 (TTY: 711)** or consult the online pharmacy directory at **http://www.aetnamedicare.com/pharmacyhelp**. 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. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employee of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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

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

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.

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. For more information, call Aetna Medicare at **1-888-267-2637 (TTY: 711)**. We're here 8 a.m. to 6 p.m., Monday through Friday. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. 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.

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. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **http://www.aetnamedicare.com**.

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 **http://www.aetna.com**.

Important information about your enrollment in a Medicare Advantage plan:

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

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.

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 (Example: Annual Enrollment Period October 15 – December 7 of every year), or under certain special circumstances.

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:

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. 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 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 plan 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 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 plan, 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 plan 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) plan, he/she may be paid based on my enrollment in the Aetna Medicare Rx plan.

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 plan 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 plan 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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