



**Aetna Medicare<sup>SM</sup> Plan (PPO)  
Offered by Aetna Life Insurance Company**

**Annual Notice of Changes for 2015**

We are providing this information about your Medicare Advantage plan in accordance with requirements from the Centers for Medicare & Medicaid Services (CMS).

You are currently enrolled as a member of Aetna Medicare Plan (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

Please review this information as background to help you decide what coverage to choose for 2015.

**Additional Resources**

- This information is available for free in other languages. Please contact our Customer Service number at 1-855-660-1810 for additional information. (For TTY assistance please call 711). We're available 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are toll free. Customer Service also has free language interpreter services available for non-English speakers.
- Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al 1-855-660-1810. (Los usuarios de TTY deben llamar al 711). Horario de atención: de 8 a.m. a 6 p.m., Lunes a Viernes. Las personas que no hablan inglés pueden solicitar el servicio gratuito de intérpretes a Servicios al Cliente.
- This document may be made available in other formats such as Braille, large print or other alternate formats. Please contact Customer Service for more information.

**About Aetna Medicare Plan (PPO)**

- Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in Aetna Medicare depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Aetna Medicare. When it says "plan" or "our plan," it means Aetna Medicare Plan (PPO).

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## Think about Your Medicare Coverage for Next Year

You can change your coverage during your former employer/union/trust's open enrollment period each year. In addition, each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period.

It's important to review your coverage now to make sure it will meet your needs next year. To decide what's best for you, compare this information with the benefits and costs of other Medicare health plans your former employer/union/trust may offer and other individual Medicare health plans available in your area, as well as the benefits and costs of Original Medicare. **(If you drop your group retiree coverage, you may permanently lose benefits you currently receive. See Section 3.2 for more information.)**

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### Important things to do:

- Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Section 1 for information about benefit and cost changes for our plan.
  - Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1 for information about changes to our drug coverage.
  - Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our *Provider Directory*.
  - Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
  - Think about whether you are happy with our plan.**
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### If you decide to stay with Aetna Medicare (PPO) plan:

If you decide to stay with the same Aetna Medicare plan next year, your plan benefits administrator will give you instructions if there is any action you need to take to remain enrolled.

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**If you decide to change plans:**

If you decide to leave your current Aetna Medicare plan for 2015, you have choices on how to receive your Medicare benefits.

- You can change your coverage during your former employer group/union/trust open enrollment period. Your plan benefits administrator will tell you what other plan choices might be available to you under your group retiree coverage.
- You can switch to an individual Medicare health plan or to Original Medicare; however, this would mean dropping your group retiree coverage. Medicare's general annual election period for Medicare beneficiaries runs from October 15 through December 7 of 2014. Or, you may access plans in the individual marketplace at any time through a special enrollment period. Look in Section 3.2 to learn more about your choices.

**It is important that you carefully consider your decision before dropping your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your employer/union/trust retiree group coverage if you switch plans. Call Customer Service for information.**

### Summary of Important Costs for 2015

The table below compares the 2014 costs and 2015 costs for our plan in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2014 (this year)	2015 (next year)
<b>Yearly deductible</b>	In-network: <b>\$200</b>	In-network: <b>\$250</b>
	Combined In- and Out-of-Network Deductible: <b>\$200</b>	Combined In- and Out-of-Network Deductible: <b>\$250</b>
<b>Maximum out-of-pocket amounts</b> This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From in-network providers: <b>\$3,400</b>	From in-network providers: <b>\$3,400</b>
	From in-network and out-of-network providers combined: <b>\$3,400</b>	From in-network and out-of-network providers combined: <b>\$3,400</b>

Cost	2014 (this year)	2015 (next year)
<p><b>Doctor office visits</b></p>	<p>In-network: Primary care visits: You pay <b>\$0</b> copay per visit</p> <p>Specialist visits: You pay <b>\$20</b> copay per visit</p> <p>Out-of-network: Primary care visits: You pay <b>10%</b> of the cost</p> <p>Specialist visits: You pay <b>10%</b> of the cost</p>	<p>In-network: Primary care visits: You pay <b>\$0</b> copay per visit</p> <p>Specialist visits: You pay <b>\$20</b> copay per visit</p> <p>Out-of-network: Primary care visits: You pay <b>20%</b> of the cost</p> <p>Specialist visits: You pay <b>20%</b> of the cost</p>
<p><b>Inpatient hospital stays</b> Includes inpatient acute, inpatient rehabilitation, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p>	<p>In-network: <b>\$0 per admission</b></p> <p>Out-of-network: <b>10% per admission</b></p>	<p>In-network: <b>\$0 per admission</b></p> <p>Out-of-network: <b>20% per admission</b></p>
<p><b>Part D prescription drug coverage</b>  (See Section 1.6 for details.)  For a one-month (30-day) supply of a drug that is filled at a network pharmacy that provides standard cost-sharing.  The preferred drug list associated with your plan has changed since 2014. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.</p>	<p>Deductible: <b>Not Applicable</b></p> <p>Copays during the Initial Coverage Stage:</p> <p>Your plan includes Select Care generic drugs within your Tier 1 coverage.</p> <p>Select Care generics cost share:  You pay a <b>\$0</b> copay</p>	<p>Deductible: <b>Not Applicable</b></p> <p>Copays during the Initial Coverage Stage:</p> <p>Your plan includes Select Care generic drugs in a separate tier of coverage; they will be included in the highest numbered drug tier.</p> <p>Select Care generics cost share:  You pay a <b>\$0</b> copay</p>

Cost	2014 (this year)	2015 (next year)
	Tier 1 Other generic drugs: You pay a <b>\$10</b> copay	Tier 1 Other generic drugs: You pay a <b>\$10</b> copay
	Tier 2 Preferred brand: You pay a <b>\$30</b> copay	Tier 2 Preferred brand: You pay a <b>\$30</b> copay
	Tier 3 Non-preferred brand: You pay a <b>\$45</b> copay	Tier 3 Non-preferred brand: You pay a <b>\$45</b> copay

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## SECTION 1 Changes to Benefits and Costs for Next Year

### Section 1.1 – Changes to the Monthly Premium (if applicable)

Your coverage is provided through contract with your current employer or former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable). (You must continue to pay your Medicare Part B premium.)

If Aetna bills you directly for your total plan premium, we will mail you a letter detailing your new plan premium amount when the new amount has been determined. (You must also continue to pay your Medicare Part B premium.)

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

### Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. These limits are called the “maximum out-of-pocket amounts.” Once you reach the maximum out-of-pocket amounts, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2014 (this year)	2015 (next year)
<p><b>In-network maximum out-of-pocket amount</b></p> <p>Your costs for covered medical services (such as copays and deductibles, if applicable) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium (if applicable) and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	<b>\$3,400</b>	<b>\$3,400</b>
		<p>Once you have paid <b>\$3,400</b> out-of-pocket for covered Part A and Part B services from in-network providers, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.</p>

Cost	2014 (this year)	2015 (next year)
<p><b>Combined maximum out-of-pocket amount</b></p> <p>Your costs for covered medical services (such as copays and deductibles, if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) does not count toward your maximum out-of-pocket amount.</p>	<p><b>\$3,400</b></p>	<p style="text-align: center;"><b>\$3,400</b></p> <p>Once you have paid <b>\$3,400</b> out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.</p>

### Section 1.3 – Changes to the Provider Network

There are changes to our network of doctors and other providers for next year.

An updated *Provider Directory* is located on our website at: <http://www.aetnaretireplans.com>. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2015 *Provider Directory* to see if your providers are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

## Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. Your new pharmacy network for 2015 is the *Group Value Network*. This is also listed on page 1 of your Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance). Please refer to this network name when attempting to locate 2015 network pharmacies.

Our *Pharmacy Directory* gives you a complete list of our network pharmacies. An updated *Pharmacy Directory* is located on our website at <http://www.aetnaretireplans.com>. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2015 Pharmacy Directory to see which pharmacies are in your new 2015 pharmacy network.**

## Section 1.5 – Changes to Benefits and Costs for Medical Services

Any changes to your 2015 plan coverage will be included below. If there are no changes or if you need additional details about the coverage and costs for services, see the 2015 Medical Benefits Chart (Schedule of Copayments/Coinsurance) included in this package.

Cost	2014 (this year)	2015 (next year)
<b>Yearly deductible</b>	In-network: <b>\$200</b>	In-network: <b>\$250</b>
	Combined In- and Out-of- Network Deductible: <b>\$200</b>	Combined In- and Out-of- Network Deductible: <b>\$250</b>
<b>Cardiac rehabilitation services</b>	In-network: You pay a <b>\$20</b> copay per visit	In-network: You pay a <b>\$20</b> copay per visit
	Out-of-network: You pay <b>10%</b> of the cost	Out-of-network: You pay <b>20%</b> of the cost
<b>Chiropractic services</b>	In-network: You pay a <b>\$20</b> copay per visit	In-network: You pay a <b>\$20</b> copay per visit
	Out-of-network: You pay <b>10%</b> of the cost of the visit	Out-of-network: You pay a <b>20%</b> copay per visit



Cost	2014 (this year)	2015 (next year)
	Out-of-network: You pay <b>10%</b> of the cost of the service	Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Durable medical equipment and related supplies</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the equipment and related supplies	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the equipment and related supplies
<b>Enhanced blood benefit</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Home health agency care</b>	In-network: You pay a <b>\$0</b> copay per visit  Out-of-network: You pay <b>10%</b> of the cost of the visit	In-network: You pay a <b>\$0</b> copay per visit  Out-of-network: You pay <b>20%</b> of the cost of the visit
<b>Inpatient dialysis</b>	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>10%</b> per admission	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>20%</b> per admission
<b>Inpatient hospital care</b>	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>10%</b> per admission	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>20%</b> per admission
<b>Inpatient mental health care</b>	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>10%</b> per admission	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>20%</b> per admission

Cost	2014 (this year)	2015 (next year)
<b>Lab service</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Medicare Part B prescription drugs</b>	In-network: <b>\$0</b> copay for Medicare Part B drugs  Out-of-network: You pay <b>10%</b> of the cost of the Medicare Part B drugs	In-network: <b>\$0</b> copay for Medicare Part B drugs  Out-of-network: You pay <b>20%</b> of the cost of the Medicare Part B drugs
Allergy shots	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Medicare-covered dental services</b>	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Medicare-covered hearing services</b>	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Medicare-covered vision services</b>	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service

Cost	2014 (this year)	2015 (next year)
<b>Outpatient hospital services</b>	<p>In-network: You pay a <b>\$0</b> copay per service</p> <p>Out-of-network: You pay <b>10%</b> of the cost of the service</p>	<p>In-network: You pay a <b>\$0</b> copay per service</p> <p>Out-of-network: You pay <b>20%</b> of the cost of the service</p>
<b>Outpatient medical/surgical supplies</b>	<p>In-network: You pay <b>\$0</b> copay for supplies received during a PCP visit</p> <p>You pay <b>\$20</b> copay for supplies received from other network providers</p> <p>Out-of-network: You pay <b>10%</b> of the cost for supplies received during a PCP visit</p> <p>You pay <b>10%</b> of the cost for supplies received from other network providers</p>	<p>In-network: You pay <b>\$0</b> copay for supplies received during a PCP visit</p> <p>You pay <b>\$20</b> copay for supplies received from other network providers</p> <p>Out-of-network: You pay <b>20%</b> of the cost for supplies received during a PCP visit</p> <p>You pay <b>20%</b> of the cost for supplies received from other network providers</p>
<b>Outpatient mental health care</b>	<p>In-network: You pay a <b>\$0</b> copay per service</p> <p>Out-of-network: You pay <b>10%</b> of the cost of the service</p>	<p>In-network: You pay a <b>\$0</b> copay per service</p> <p>Out-of-network: You pay <b>20%</b> of the cost of the service</p>
<b>Outpatient rehabilitation services</b>	<p>In-network: You pay a <b>\$20</b> copay per service</p> <p>Out-of-network: You pay <b>10%</b> of the cost of the service</p>	<p>In-network: You pay a <b>\$20</b> copay per service</p> <p>Out-of-network: You pay <b>20%</b> of the cost of the service</p>
<b>Outpatient substance abuse services</b>	<p>In-network: You pay a <b>\$0</b> copay per service</p>	<p>In-network: You pay a <b>\$0</b> copay per service</p>

Cost	2014 (this year)	2015 (next year)
	Out-of-network: You pay <b>10%</b> of the cost of the service	Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Outpatient surgery</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Partial hospitalization services</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Medicare-covered podiatry services</b>	In-network: You pay a <b>\$20</b> copay per visit  Out-of-network: You pay <b>10%</b> of the cost of the visit	In-network: You pay a <b>\$20</b> copay per visit  Out-of-network: You pay <b>20%</b> of the cost of the visit
<b>Enhanced benefit: Non-Medicare covered routine podiatry</b>	In-network: You pay a <b>\$20</b> copay per visit  Out-of-network: You pay <b>10%</b> of the cost of the visit	In-network: You pay a <b>\$20</b> copay per visit  Out-of-network: You pay <b>20%</b> of the cost of the visit
<b>Primary care doctor visit</b>	In-network: You pay a <b>\$0</b> copay per office visit  Out-of-network: You pay <b>10%</b> of the cost of the office visit	In-network: You pay a <b>\$0</b> copay per office visit  Out-of-network: You pay <b>20%</b> of the cost of the office visit
<b>Prosthetic devices and related</b>	In-network: You pay a <b>\$0</b> copay for	In-network: You pay a <b>\$0</b> copay for

Cost	2014 (this year)	2015 (next year)
<b>supplies</b>	prosthetic devices and related supplies  Out-of-network: You pay <b>10%</b> of the cost of the prosthetic devices and related supplies	prosthetic devices and related supplies  Out-of-network: You pay <b>20%</b> of the cost of the prosthetic devices and related supplies
<b>Pulmonary rehabilitation services</b>	In-network: You pay a <b>\$20</b> copay per visit  Out-of-network: You pay <b>10%</b> of the cost of the visit	In-network: You pay a <b>\$20</b> copay per visit  Out-of-network: You pay <b>20%</b> of the cost of the visit
<b>Skilled nursing facility (SNF) care</b>	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>10%</b> per admission	In-network: You pay <b>\$0</b> per admission  Out-of-network: You pay <b>20%</b> per admission
<b>Specialist visit</b>	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$20</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Therapeutic radiology service</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service
<b>Medicare covered routine X-ray</b>	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>10%</b> of the cost of the service	In-network: You pay a <b>\$0</b> copay per service  Out-of-network: You pay <b>20%</b> of the cost of the service

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## Section 1.6 – Changes to Part D Prescription Drug Coverage

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### Changes to basic rules for the plan's Part D drug coverage

Effective June 1, 2015, before your drugs can be covered under the Part D benefit, CMS will require your doctors and other prescribers to either accept Medicare or to file documentation with CMS showing that they are qualified to write prescriptions.

### Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **Current members** can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, you'll be able to get your drug at the start of the new plan year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we will cover a **one-time**, temporary supply. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- You and your doctor can ask the plan to make an exception for you and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* included with this *Annual Notice of Changes*. Look for Chapter 9, Section 6 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Transition applies to all Part D prescription medications not included on the formulary, or that are on our formulary but with a restriction, such as prior authorization or step therapy. It is anticipated that transition determination will occur at the point-of sale. However, determination of Part D vs. Part B drugs may require physician intervention to make actual determination and therefore may not be resolved at the point-of-sale.

- If you are a currently enrolled member who does not request an exception before January 1, 2015, and your current drug therapy is impacted by a formulary change, we will cover up to a 30-day temporary supply (unless your prescription is written for fewer days) of the drug for the first 90 days of the new plan year starting on January 1.
- If you are a currently enrolled member and a resident of a long-term care facility and do not request an exception before January 1, 2015 and your current drug therapy is impacted by a formulary change, we will allow you to refill your prescription until we have provided you with at least 91 and up to a 98-day transition supply, consistent with the dispensing increment (unless your prescription is written for fewer days). We will cover more than one refill of this drug for the first 90 days of the new plan year starting on January 1.
- If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with temporary coverage (up to a 30-day supply) for the applicable drug(s).

Regardless of why you received a temporary supply, you will need to utilize our exception process, as defined in the *Evidence of Coverage* that was in the mailing with this *Annual Notice of Changes*, if you need to continue on the current drug.

**Important Note:** Please take advantage of filing your exception requests before January 1. It will make for a very easy transition into the next calendar year for you. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this Annual Notice of Changes. Look for Chapter 9 of the *Evidence of Coverage* (What to do if you have a problem or complaint).

## Changes to Prescription Drug Costs

*Note:* If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you get “Extra Help” and haven’t received this insert by September 30, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

## Changes to the Deductible Stage

Cost	2014 (this year)	2015 (next year)
<b>Stage 1: Yearly Deductible Stage</b>	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

## Changes to Your Copayments in the Initial Coverage Stage

Cost	2014 (this year)	2015 (next year)
<p><b>Stage 2: Initial Coverage Stage</b></p> <p>During this stage, the plan pays its share of the cost of your drugs and <b>you pay your share of the cost.</b></p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in the 2015 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included in this packet.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p> <p>The preferred drug list associated with your plan has changed since 2014. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Your plan includes Select Care generic drugs within your Tier 1 coverage.</p> <p>Select Care generics cost share: You pay a <b>\$0</b> copay</p> <p>Tier 1 Other generic drugs: You pay a <b>\$10</b> copay</p> <p>Tier 2 Preferred brand: You pay a <b>\$30</b> copay</p> <p>Tier 3 Non-preferred brand: You pay a <b>\$45</b> copay</p> <p>Once your total drug costs have reached <b>\$2,850</b>, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Your plan includes Select Care generic drugs in a separate tier of coverage; they will be included in the highest numbered drug tier.</p> <p>Select Care generics cost share: You pay a <b>\$0</b> copay</p> <p>Tier 1 Other generic drugs: You pay a <b>\$10</b> copay</p> <p>Tier 2 Preferred brand: You pay a <b>\$30</b> copay</p> <p>Tier 3 Non-preferred brand: You pay a <b>\$45</b> copay</p> <p>Once your total drug costs have reached <b>\$2,960</b>, you will move to the next stage (the Coverage Gap Stage).</p>

## Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look in the 2015 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included in this packet.

## SECTION 2 Other Changes

Process	2014 (this year)	2015 (next year)
For 2015, emergency care and urgently needed care benefits are not subject to deductibles, but any out-of-pocket amounts you pay for these benefits will be credited towards the plan deductible value (if applicable) listed on page 1 of the Medical Benefits Chart (Schedule of Copayments/Coinsurance) included in this booklet.		
<b>Medicare Advantage Contract Number Change</b> Your Medicare Advantage contract (plan) number may be changing. The contract change itself does not affect your plan or benefits in any way.		
If you reside in:	2014 Contract number	2015 Contract number
AZ	H8684	H5521
DE	H8684	H5521
GA	H1110	H5521
TX	H4524	H5521
All other states	H5521	H5521 (No change)

## SECTION 3 Deciding Which Plan to Choose

### Section 3.1 – If You Want to Stay in Aetna Medicare Plan (PPO)

If you decide to stay in the same Aetna Medicare plan, your plan benefits administrator will give you instructions if there is any action you need to take to remain enrolled.

### Section 3.2 – If You Want to Change Plans

We hope to keep you as a member next year but if you want to change for 2015 follow these steps:

#### Step 1: Learn about and compare your choices

- You can join a different Medicare health plan. Your plan benefits administrator will let you know what options are available to you under your group retiree coverage. You can also switch to an individual Medicare health plan.
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

**Please check with the benefits administrator of your employer or retiree group before you change your plan. This is important because you may permanently lose benefits you currently receive under your employer or retiree group coverage if you switch plans.**

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2015*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <http://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Aetna Medicare offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

## Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from our plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

## SECTION 4 Deadline for Changing Plans

You may be able to change to a different plan during your former employer/union/trust’s open enrollment period. Your plan may allow you to make changes at other times as well. Your plan’s benefits administrator will let you know what other plan options may be available to you.

If you want to withdraw from your group coverage and change to an Individual plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2015.

**Please check with the benefits administrator of your employer or retiree group before you change your plan. This is important because you may permanently lose benefits you currently receive under your employer or retiree group coverage if you switch plans.**

**Are there other times of the year to make a change?**

As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your employer/union/trust's plan. In certain other situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you don't like your plan choice for 2015, you can switch to Original Medicare between January 1 and February 14, 2015. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

## SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. SHIPs are independent (not connected with any insurance company or health plan). They are state programs that get money from the federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call your SHIP at the phone number in Addendum A at the back of the *Evidence of Coverage*.

## SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. There are two basic kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - 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; or
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** Many states have state pharmaceutical assistance programs (SPAPs) that help people pay for prescription drugs based on their financial need, age, or medical condition. Each state has different rules. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Addendum A at the back of the *Evidence of Coverage*).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the state ADAP. For information

on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP (the name and phone numbers for this organization are in Addendum A at the back of the *Evidence of Coverage*).

## SECTION 7 Questions?

### Section 7.1 – Getting Help from Aetna Medicare Plan (PPO)

Questions? We're here to help. Please call Customer Service at the toll free telephone number on the back of your Aetna member ID card or our general customer service center at 1-855-660-1810. (For TTY assistance, please call 711). We're available for phone calls 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are toll free.

#### **Read your 2015 *Evidence of Coverage* (it has details about next year's benefits and costs)**

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2015. For details, look in the 2015 *Evidence of Coverage* for our plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* was included in this envelope.

#### **Visit our website**

You can also visit our website at: (<http://www.aetnaretireeplans.com>). As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

### Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

#### **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

#### **Visit the Medicare website**

You can visit the Medicare website (<http://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on "Find health & drug plans.")

#### **Read *Medicare & You 2015***

You can read *Medicare & You 2015 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.