



**Aetna MedicareSM Plan (PPO)
Offered by Aetna Life Insurance Company**

Annual Notice of Changes for 2016

November 2015

Dear Member,

Thank you for your membership in Aetna Medicare.

Enclosed are your 2016 Annual Notice of Changes (ANOC), Evidence of Coverage (EOC), and Formulary (list of covered drugs) documents. 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.*

Your former employer/union/trust may not have finalized your 2016 Medicare plan benefits by the time we were required to mail this information. If your former employer/union/trust makes additional changes to your final Medicare plan costs or benefits after you receive this package, you will receive an updated 2016 benefits communication from Aetna Medicare.

Please review this information as background to help you decide what coverage to choose for 2016.

If you have questions, we're here to help. Please call Customer Service at 1-888-267-2637. (For TTY assistance please dial 711.) We're available 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are toll free. You can also visit our website at <http://www.aetnaretireplans.com>.

We value your membership and hope to continue to serve you next year.

Sincerely,

Aetna Medicare

Additional Resources

- This information is available for free in other languages. Please contact our Customer Service number at 1-888-267-2637 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 1-888-267-2637. (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 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.
- 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).

Plans are offered by Aetna Health Inc., Aetna Health of California Inc. and 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.

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. **(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 the benefits administrator of your employer or retiree group for information. See Section 3.2 for more information.)**

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 1.5 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 1.6 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.**

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.

If you decide to change plans:

If you decide to leave your current Aetna Medicare plan for 2016, 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 2015. 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 the benefits administrator of your employer or retiree group for information.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 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.**

Stage	2015 (this year)	2016 (next year)
Deductible	Network: \$250	Network: \$250
	Combined In- and Out-of-Network Deductible: \$250	Combined In- and Out-of-Network Deductible: \$250
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: \$3,400	From network providers: \$3,400
	From network and out-of-network providers combined: \$3,400	From network and out-of-network providers combined: \$3,400

Stage	2015 (this year)	2016 (next year)
<p>Doctor office visits</p>	<p>Network:</p> <p>Primary care visits:</p> <p>You pay \$0 copay per visit</p> <p>Specialist visits:</p> <p>You pay a \$20 copay per visit</p> <p>Out-of-network:</p> <p>Primary care visits:</p> <p>You pay 20% of the total cost</p> <p>Specialist visits:</p> <p>You pay 20% of the total cost</p>	<p>Network:</p> <p>Primary care visits:</p> <p>You pay \$0 copay per visit</p> <p>Specialist visits:</p> <p>You pay a \$20 copay per visit</p> <p>Out-of-network:</p> <p>Primary care visits:</p> <p>You pay 20% of the total cost</p> <p>Specialist visits:</p> <p>You pay 20% of the total cost</p>
<p>Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals 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>Network:</p> <p>\$0 per stay</p> <p>Out-of-network:</p> <p>20% per stay</p>	<p>Network:</p> <p>\$0 per stay</p> <p>Out-of-network:</p> <p>20% per stay</p>
<p>Part D prescription drug coverage (See Section 1.6 for details.)</p>	<p>Deductible:</p> <p>Not Applicable</p>	<p>Deductible:</p> <p>Not Applicable</p>

Stage	2015 (this year)	2016 (next year)
<p>For a one-month (30-day) supply of a drug that is filled at a network pharmacy that provides standard cost-sharing.</p> <p>The preferred drug list associated with your plan has changed since 2015. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.</p>	<p>Copays during the Initial Coverage Stage:</p> <p>Your plan includes Select Care generic drugs in a separate tier of coverage; they are included in the highest numbered drug tier. Select Care generic drugs cost share:</p> <p>Generic: \$10</p> <p>Preferred Brand: \$30</p> <p>Non-Preferred Brand: \$45</p>	<p>Copays during the Initial Coverage Stage:</p> <p>Select Care generic drugs are now covered in Tier 1.</p> <p>Generic: \$10</p> <p>Preferred Brand: \$30</p> <p>Non-Preferred Brand: \$45</p>

Annual Notice of Changes for 2016

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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 a with your 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 an annual coupon book detailing your premium amount. (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 this amount, you pay nothing for covered Part A and Part B services for the rest of the year.

Stage	2015 (this year)	2016 (next year)
<p>Network maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and deductibles, if applicable) from network providers count toward your 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>	<p>\$3,400</p>	<p style="text-align: center;">\$3,400</p> <p>Once you have paid \$3,400 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.</p>

Stage	2015 (this year)	2016 (next year)
Combined maximum out-of-pocket amount	\$3,400	\$3,400
Your costs for covered medical services (such as copays and deductibles, if applicable) from network and out-of-network providers count toward your combined 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.		Once you have paid \$3,400 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 network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of 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 2016 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) 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. Page 1 of your Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) lists the name of your 2016 pharmacy network. Please refer to this network name when attempting to locate 2016 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.aetnaretireeplans.com>. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2016 Pharmacy Directory to see which pharmacies are in your new 2016 pharmacy network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

Any changes to your 2016 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 2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance) included in this package.

Stage	2015 (this year)	2016 (next year)
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Section 1.6 – Changes to Part D Prescription Drug Coverage

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. **We encourage current members** to ask for an exception before next 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.
- **Work with your doctor (or other prescriber) to 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 in the first 90 days of coverage of the plan year or coverage. (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. Your doctor can help 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, 2016, 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, 2016 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

Stage	2015 (this year)	2016 (next year)
Stage 1: Yearly Deductible Stage	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 Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2015 (this year)	2016 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the total cost.</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 2016 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included in this packet.</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 their own coverage tier.</p> <p>Select Care generics cost share:</p> <p>\$0</p> <p>Generic: \$10</p> <p>Preferred Brand: \$30</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Select Care generic drugs are now covered in Tier 1</p> <p>Generic: \$10</p> <p>Preferred Brand: \$30</p> <p>Non-Preferred Brand: \$45</p>

Stage	2015 (this year)	2016 (next year)
<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 2016. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.</p>	<p>Non-Preferred Brand: \$45</p> <hr/> <p>Once your total drug costs have reached \$2,960, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once your total drug costs have reached \$3,310, 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 2016 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) included in this packet.

SECTION 2 Other Changes

Process	2015 (this year)	2016 (next year)
<p>Select Care Generic Drug Coverage</p>	<p>Your plan included Select Care generic drugs in a separate tier of coverage; they were in the highest numbered drug tier.</p>	<p>Your 2016 plan now includes Select Care generic drugs in Tier 1.</p> <p>If your covered drug costs less than the copayment amount listed in the chart, you'll pay that lower price for the drug. You'll pay either the full price of the drug or the copayment amount, whichever is lower.</p>
<p>If Aetna billed you directly for your monthly plan premium in 2015 there will be a change. In 2015 you received a monthly invoice. In 2016 Aetna will provide you with an annual coupon book.</p>		

Process	2015 (this year)	2016 (next year)
For 2016, emergency care and urgently needed service benefits are not subject to your plan deductible. The out-of-pocket amounts that you pay for these benefits will no longer be credited towards the plan deductible value (if applicable) listed on page 1 of the Medical Benefits (Schedule of Copayments/Coinsurance) included in this booklet.		

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 2016 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 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.

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 the benefits administrator of your employer or retiree group for information.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, 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 drop from your group retiree 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, 2016.

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 the benefits administrator of your employer or retiree group for information.

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 2016, you can switch to Original Medicare between January 1 and February 14, 2016. 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. Below we list different 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 (applications); or
 - Your State Medicaid Office (applications).
- **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 1-888-267-2637. (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 2016 *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 2016. For details, look in the 2016 *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* is included in this envelope.

Visit our Website

You can also visit our website at <http://www.aetnaretireplans.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our pharmacy network (Pharmacy 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 2016*

You can read *Medicare & You 2016* 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.

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

AETNA LIFE INSURANCE COMPANY

Contract Holder Name: **STATE OF MAINE**

Contract Holder Group Agreement Effective Date: **01/01/2016**

Contract Holder Number: **457677**

This Medical Benefits Chart (Schedule of Copayments/Coinsurance) is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the attachment for information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, Medical Benefits Chart (what is covered and what you pay).)

Annual Deductible	FOR SERVICES RECEIVED NETWORK	FOR SERVICES RECEIVED OUT-OF-NETWORK
<p>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.</p>	<p>\$250</p> <p>Deductible waived for Preventive Services, Part B Drugs, Diabetic Supplies, Emergency Room Visits, Emergency Ambulance, Urgent Care, applicable Riders and Renal Care and TMJ</p>	<p>\$250</p> <p>Combined In- and Out-of-Network Deductible (Plan Level/includes network Deductible)</p> <p>Deductible waived for Preventive Services, Emergency Room Visits, Emergency Ambulance, Urgent Care, and applicable Riders and TMJ</p>
Annual Maximum Out-of-Pocket Limit		
<p>The maximum out-of-pocket limit applies to all covered Medicare Part A and B benefits including deductible.</p>	<p>Maximum out-of-pocket amount for network services: \$3,400</p>	<p>Combined maximum out-of-pocket amount for in- and out-of-network services: \$3,400</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Important information regarding the services listed below in the Medical Benefits Chart:

If you receive services from:	Your plan services include:	You will pay:
A primary care physician (PCP): <ul style="list-style-type: none"> • Family Practitioner • Pediatrician • Internal Medicine • General Practitioner <p>And get more than one covered service during the single visit:</p>	Copays only	One PCP copay.
	Copays and coinsurance	The PCP copay and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.
An outpatient facility, specialist or doctor who is not a PCP and get more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

 You will see this apple next to the Medicare covered preventive services in the benefits chart.

Services that are covered for you	What you must pay (after deductible listed on page 1) when you get these services	What you must pay (after deductible listed on page 1) when you get these services
	Network	Out-of-network
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.	20% of the cost of the service
Ambulance services* <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance 	\$0 copay for each Medicare-covered ambulance benefit (one way)	\$0 copay for each Medicare-covered ambulance benefit (one way)

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan.</p> <ul style="list-style-type: none"> • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required. <p>*Prior authorization rules apply for air ambulance transfers and non-emergency transportation by ground ambulance or medical van. Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p>Annual physical exam</p> <p>The annual physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam; a heart and lung exam; an abdominal exam; a neurological exam; a dermatological exam, and an extremities exam.</p> <ul style="list-style-type: none"> • Limited to one physical exam per year. 	<p>\$0 copay for the exam</p>	<p>20% of the cost of the exam</p>
<p> Annual wellness visit</p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can’t take place within 12 months of your “Welcome to</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>	<p>20% of the cost of the visit</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Out-of-network</p>
<p>Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>		
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>	<p>20% of the cost of the service</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>	<p>20% of the cost of the service</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$20 copay for each Medicare-covered cardiac rehabilitation visit</p>	<p>20% of the cost for each Medicare-covered cardiac rehabilitation visit</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>	<p>20% of the cost of the service</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Out-of-network</p>
<p>pressure, and give you tips to make sure you're eating well.</p>		
<p> Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>	<p>20% of the cost of the service</p>
<p> Cervical and vaginal cancer screening Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>	<p>20% of the cost of the service</p>
<p>Chiropractic services</p> <ul style="list-style-type: none"> • We cover manual manipulation of the spine to correct subluxation <p>Enhanced benefit: Non-Medicare covered chiropractic services are provided each calendar year at a licensed chiropractor</p>	<p>\$20 copay per Medicare-covered visit</p> <p>\$20 copay for each visit</p>	<p>20% of the cost of each Medicare-covered visit</p> <p>\$20 copay for each visit</p>
<p> Colorectal cancer screening For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>	<p>20% of the cost of the service</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Out-of-network</p>
<p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 		
<p>Compression stockings</p>	<p>You pay \$0 per item</p>	<p>You pay 20% per item</p>
<p> Depression screening</p> <p>We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>	<p>20% of the cost of the service</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>	<p>20% of the cost for Diabetes screening performed by a PCP</p> <p>20% of the cost for Diabetes screening performed by other providers</p>
<p>Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, urine test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors 	<p>\$0 copay per Medicare-covered diabetic shoes/inserts, service or supply</p> <p>\$0 copay for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit.</p>	<p>20% of the cost per Medicare-covered diabetic shoes/inserts, service or supply</p> <p>20% of the cost for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit provided by your PCP</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Diabetes self-management training is covered under certain conditions 		<p>20% of the cost for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit provided by other providers.</p>
<p>Durable medical equipment and related supplies*</p> <p>(For a definition of “durable medical equipment,” see the final chapter (“Definitions of important words”) of the <i>Evidence of Coverage</i>.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, wigs, and walker.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p> <p>Coverage for wigs is included when plan criteria is met.</p> <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$0 copay for each Medicare-covered item</p>	<p>20% of the cost for each Medicare-covered item</p> <p>\$0</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>This coverage is available worldwide.</p>	<p>\$65 copay for each Medicare-covered emergency room visit</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit</p>	<p>\$65 copay for each Medicare-covered emergency room visit</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p>
<p>Deductible does not apply to emergency care.</p>		
<p> Health and wellness education programs</p> <ul style="list-style-type: none"> • Aetna Health ConnectionsSM — Disease Management This program provides individualized education and support for select chronic conditions. It can help you learn about how to manage your chronic health conditions and achieve your optimal state of health. 	<p>Included in your plan</p>	

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> <p>• Case Management Services A medical condition may qualify you for an individually assigned nurse case manager who will coordinate with your physicians to help so you can get well and stay healthy.</p> <p>• Fitness Benefit The Aetna fitness benefit gives you free monthly membership at participating fitness clubs and facilities. Plan members who don't live close to a participating facility or want to exercise at home can order a home fitness kit. We work with another company to manage this benefit.</p> <p>• Aetna Lifestyle Coaching Program Offered through HealthyroadsTM and provides members with ongoing support and coaching to make positive changes in their health. The goal is to provide the most effective, individually focused intervention that seeks to change health behaviors and improve health. Members may receive a weekly 30 minute one-on-one telephonic based coaching session for stress management, nutrition, tobacco cessation and exercise. Lifestyle coaching includes telephonic coaching, online tools, educational resources, and Milestone Kits.</p> <p>• Informed Health[®] Line Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options.</p> <p>• Telemonitoring for hypertension This program is designed to help members diagnosed with uncontrolled hypertension (defined as blood pressure >140/90) to manage their blood pressure. Members who choose to</p> 	<p style="text-align: center;">Included in your plan</p> <p>SilverSneakers[®] Fitness Program is included in your plan. We're here to help and give you more information.</p> <ul style="list-style-type: none"> • Call us at 1-888-423-4632. (For TTY/TDD assistance please dial 711.) • Visit http://www.silversneakers.com. <p>Aetna Lifestyle Coaching Program is included in your plan.</p> <ul style="list-style-type: none"> • Enroll by phone: 1-800 650-2747. (For TTY/TDD assistance please dial 711.) • Visit http://www.Healthyroads.com for additional information 	<p style="text-align: center;">Included in your plan</p> <p style="text-align: center;">Included in your plan</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Out-of-network</p>
<p>enroll in the program receive a free automatic blood pressure monitor, weekly calls to monitor their blood pressure and educational material. Some members may also receive extra support from a case manager.</p>		
<p>Hearing services</p> <ul style="list-style-type: none"> • Medicare covered diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Our plan covers one routine hearing exam every 12 months 	<p>\$20 copay for basic hearing evaluations</p> <p>\$0 copay for one routine hearing exam every 12 months</p>	<p>20% of the cost for basic hearing evaluations</p> <p>20% of the cost for one routine hearing exam every 12 months</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</p>	<p>20% of the cost of the service</p>
<p>Home health agency care*</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services 	<p>\$0 copay for each Medicare-covered home health visit, plus applicable DME cost-sharing for any covered supplies</p>	<p>20% of the cost for each Medicare-covered home health visit, plus applicable DME cost-sharing for any covered supplies</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>combined must total fewer than 8 hours per day and 35 hours per week)</p> <ul style="list-style-type: none"> Physical therapy, occupational therapy, and speech therapy Medical and social services Medical equipment and supplies <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Drugs for symptom control and pain relief Short-term respite care Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p><u>Hospice care (continued)</u></p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan’s network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). However, after payment, you can ask us to pay you back for the difference between the cost-sharing in our plan and the cost-sharing under Original Medicare. <p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers may lower your share of the costs for the services.</p> <p><u>For drugs that may be covered by the plan’s Part D benefit:</u> Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you’re in Medicare-certified hospice</i>).</p>		

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit. Palliative care consultation is also available.</p>	<p>Included service in Inpatient hospital care; Physician services cost-sharing applies for outpatient consultations.</p>	<p>Included service in Inpatient hospital care; Physician services cost-sharing applies for outpatient consultations.</p>
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p> <p>\$0 copay for other Medicare-covered vaccines</p> <p>Office visit cost-share may apply if additional services are received</p>	<p>\$0 copay for flu and pneumonia vaccines</p> <p>20% of the cost for other Medicare-covered vaccines</p> <p>Office visit cost-share may apply if additional services are received</p>
<p>Inpatient hospital care*</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term hospitals 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>There is no limit to the number of days covered by the plan for each hospital stay. Covered services include:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) 	<p>For Medicare-covered hospital stays, you pay:</p> <p>\$0 per stay</p>	<p>For Medicare-covered hospital stays:</p> <p>20% per stay</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost-sharing you would pay at a network hospital.</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. A complete list of Medicare-approved transplant centers and facilities that participate in our plan’s Institutes of Excellence network can be found in the <i>Provider Directory</i> and on our website at www.aetnaretireplans.com. • Blood - including storage and administration. • Physician services 		

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p>Inpatient mental health care*</p> <ul style="list-style-type: none"> Covered services include mental health care services that require a hospital stay. <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>For Medicare-covered hospital stays, you pay:</p> <p>\$0 per stay</p>	<p>For Medicare-covered hospital stays, you pay:</p> <p>20% per stay</p>
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled</p>	<p>\$0 copay for each primary care doctor visit for Medicare-covered benefits</p>	<p>20% of the cost for each primary care doctor visit for Medicare-covered benefits</p>

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<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<p>nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition • Physical therapy, speech therapy, and occupational therapy 	<p>\$20 copay for each specialist visit for Medicare-covered benefits</p> <p>\$0 for Medicare-covered diagnostic procedures or tests</p> <p>\$0 for Medicare-covered lab services</p> <p>\$0 for Medicare-covered X-rays</p> <p>\$0 for Medicare-covered diagnostic radiology and complex imaging services</p> <p>\$0 for Medicare-covered therapeutic radiology services</p> <p>\$0 copay for Medicare-covered medical supply items received from a PCP</p> <p>\$20 copay for Medicare-covered medical supply items received from other providers</p>	<p>20% of the cost for each specialist visit for Medicare-covered benefits</p> <p>20% of the cost per test for Medicare-covered diagnostic procedures or tests</p> <p>20% of the cost for Medicare-covered lab services</p> <p>20% of the cost for each Medicare-covered X-ray</p> <p>20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service</p> <p>20% of the cost for Medicare-covered therapeutic radiology services</p> <p>20% of the cost of service medical supply items received from a PCP</p> <p>20% of the cost of service medical supply items received from other providers</p>

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<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
	<p>\$0 copay for each Medicare-covered prosthetic and orthotic item</p> <p>\$0 copay for each Medicare-covered DME item</p> <p>\$20 copay for each Medicare-covered physical, speech or occupational therapy visit</p>	<p>20% of the cost for each Medicare-covered prosthetic and orthotic item</p> <p>20% of the cost for each Medicare-covered DME item</p> <p>20% of the cost for each Medicare-covered physical, speech or occupational therapy visit</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 3 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.</p>	<p>20% of the cost of the service</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p>	<p>\$0 copay per prescription or refill</p>	<p>20% of the cost per prescription or refill</p>

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<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p>
	<p>Network</p>	<p>Out-of-network</p>
<ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 		
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>	<p>20% of the cost of the service</p>

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Services that are covered for you	What you must pay (after deductible listed on page 1) when you get these services Network	What you must pay (after deductible listed on page 1) when you get these services Out-of-network
your primary care doctor or practitioner to find out more.		
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Medicare covered X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Diagnostic Radiology and complex imaging such as: MRI, MRA, PET scan • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Home PT/INR monitoring is covered for chronic, oral anticoagulation management for members on warfarin with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism). The monitor and the home testing are covered for members who meet certain conditions and when it is prescribed by a doctor treating their condition. • Blood - including storage and administration. • Other outpatient diagnostic tests <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits</p> <p>\$0 for Medicare-covered X-rays</p> <p>\$0 for Medicare-covered diagnostic radiology and complex imaging services</p> <p>\$0 for Medicare-covered lab services</p> <p>\$0 for Medicare-covered diagnostic procedures or tests</p>	<p>20% of the cost for each primary care doctor visit for Medicare-covered benefits</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits</p> <p>20% of the cost for each Medicare-covered X-ray</p> <p>20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service</p> <p>20% of the cost for Medicare-covered lab services</p> <p>20% of the cost per test for Medicare-covered diagnostic procedures or tests</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible listed on page 1) when you get these services Network	What you must pay (after deductible listed on page 1) when you get these services Out-of-network
	<p>\$0 for Medicare-covered therapeutic radiology services</p> <p>\$0 copay for Medicare-covered medical supply items received from a PCP</p> <p>\$20 copay for Medicare-covered medical supply items received from other providers</p> <p>\$20 copay for each Medicare-covered Home INR monitor/test</p>	<p>20% of the cost for Medicare-covered therapeutic radiology services</p> <p>20% of the cost of service medical supply items received from a PCP</p> <p>20% of the cost of service medical supply items received from other providers</p> <p>20% of the cost for each Medicare-covered Home INR monitor/test.</p>
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services 	<p>\$0 per facility visit</p>	<p>20% per facility visit</p>

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Services that are covered for you	What you must pay (after deductible listed on page 1) when you get these services Network	What you must pay (after deductible listed on page 1) when you get these services Out-of-network
<ul style="list-style-type: none"> Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits</p> <p>\$0 for Medicare-covered lab services</p> <p>\$0 for Medicare-covered diagnostic procedures or tests</p> <p>\$0 copay for each Medicare-covered mental health care visit</p> <p>\$0 for Medicare-covered X-rays</p> <p>\$0 for Medicare-covered diagnostic radiology and complex imaging services</p>	<p>20% of the cost for each primary care doctor visit for Medicare-covered benefits</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits</p> <p>20% of the cost for Medicare-covered lab services</p> <p>20% of the cost per test for Medicare-covered diagnostic procedures or tests</p> <p>20% of the cost for each Medicare-covered mental health care visit</p> <p>20% of the cost for each Medicare-covered X-ray</p> <p>20% of the cost for each Medicare-covered diagnostic radiology and complex imaging service</p>

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<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
	<p>\$0 for Medicare-covered therapeutic radiology services</p> <p>\$0 copay for Medicare-covered medical supply items received from a PCP</p> <p>\$20 copay for Medicare-covered medical supply items received from other providers</p> <p>\$0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself</p>	<p>20% of the cost for Medicare-covered therapeutic radiology services</p> <p>20% of the cost for Medicare-covered medical supply items received from a PCP</p> <p>20% of the cost of service medical supply items received from other providers</p> <p>20% of the cost per prescription or refill for certain drugs and biologicals that you can't give yourself</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$0 copay for each Medicare-covered individual or group therapy visit</p>	<p>20% of the cost for each Medicare-covered individual or group therapy visit</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist</p>	<p>\$20 copay for each Medicare-covered outpatient rehabilitation service visit</p>	<p>20% of the cost for each Medicare-covered outpatient rehabilitation service visit</p>

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<p>offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>		
<p>Outpatient substance abuse services</p>	<p>\$0 copay for each Medicare-covered individual or group therapy visit</p>	<p>20% of the cost for each Medicare-covered individual or group therapy visit</p>
<p>Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>If you receive multiple services in one visit, you generally pay only the cost-sharing of the highest-cost service.</p>	
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>\$0 copay for each Medicare-covered visit</p>	<p>20% of the cost for each Medicare-covered visit</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p>	<p>Your cost-share is based on:</p> <ul style="list-style-type: none"> - the tests/services/ supplies you receive - the provider of the tests/services/ supplies 	

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<ul style="list-style-type: none"> Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, walk-in clinic, (non-urgent) or any other location Consultation, diagnosis, and treatment by a specialist Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment Telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. Second opinion by another network provider prior to surgery Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	<p>- the setting where the tests/services/ supplies are performed.</p> <p>\$0 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits</p> <p>\$20 copay for each Medicare-covered dental service</p>	<p>20% of the cost for each primary care doctor visit for Medicare-covered benefits</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits</p> <p>20% of the cost for each Medicare-covered dental service</p>
<p>Podiatry services</p> <p>Medicare covered services include:</p> <ul style="list-style-type: none"> Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care for members with certain medical conditions affecting the lower limbs <p>Enhanced benefit: Non-Medicare covered routine podiatry</p>	<p>\$20 copay for each Medicare-covered visit</p> <p>\$0 copay for routine podiatry services received from your PCP</p> <p>\$20 per visit from other providers</p>	<p>20% of the cost for each Medicare-covered visit</p> <p>20% of the cost for routine podiatry services received from your PCP</p> <p>20% per visit from other providers</p>

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 Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	There is no coinsurance, copayment, or deductible for an annual PSA test.	20% of the cost of the service
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail. * Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.	\$0 copay for each Medicare-covered item	20% of the cost for each Medicare-covered item
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	\$20 copay for each Medicare-covered pulmonary rehabilitation visit	20% of the cost for each Medicare-covered pulmonary rehabilitation visit

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<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>	<p>20% of the cost of the service</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.</p>	<p>20% of the cost of the service</p>
<p>Services to treat kidney disease and conditions*</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with 	<p>\$0 copay for kidney disease education services received from your PCP</p>	<p>20% of the cost for kidney disease education services received from your PCP</p>

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<p>stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</p> <ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the <i>Evidence of Coverage</i>) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”</p> <p>* Prior authorization rules apply for network services and will be performed by your Aetna network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>	<p>\$20 copay for kidney disease education services received from other providers</p> <p>\$0 copay for in- and out-of-area outpatient dialysis</p> <p>Inpatient dialysis – refer to inpatient hospital care at the beginning of this benefits chart</p> <p>\$0 copay for self-dialysis training received from your PCP</p> <p>\$20 copay for self-dialysis training received from other providers</p> <p>\$0 copay for home dialysis equipment and supplies</p> <p>\$0 copay for Medicare-covered home support services</p>	<p>20% of the cost for kidney disease education services received from other providers.</p> <p>\$0 copay for in- and out-of-area outpatient dialysis</p> <p>Inpatient dialysis – refer to inpatient hospital care at the beginning of this benefits chart</p> <p>20% of the cost for self-dialysis training received from your PCP</p> <p>20% of the cost for self-dialysis training received from other providers</p> <p>20% of the cost for home dialysis equipment and supplies</p> <p>20% of the cost for Medicare-covered home support services</p>
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of “skilled nursing facility care,” see the final chapter (“Definitions of important words”) of the <i>Evidence of Coverage</i>. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>100 days covered for each benefit period. Prior Hospital stay is not required.</p>	<p>\$0</p> <p>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</p>	<p>20%</p> <p>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</p>

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<p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. Under certain conditions listed below, you may be able to pay network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. <p>* Prior authorization rules apply for network services and will be performed by your Aetna</p>	<p>care in a SNF) for 60 days in a row including your day of discharge. 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.</p>	<p>care in a SNF) for 60 days in a row including your day of discharge. 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.</p>

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<p>network provider. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.</p>		
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) <u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. <u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>	<p>20% of the cost of the service</p>
<p>Temporomandibular Joint Dysfunction</p>	<p>\$0 copay for each visit</p>	<p>\$0 copay for each visit</p>
<p>Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Coverage is available worldwide.</p>	<p>\$20 copay for each Medicare-covered urgently needed care services visit</p>	<p>\$20 copay for each Medicare-covered urgently needed services visit</p>
<p>Deductible does not apply to urgently needed services.</p>		
<p> Vision care Medicare-covered services include:</p>	<p>\$20 copay for exams to diagnose and treat</p>	<p>20% of the cost for exams to diagnose and</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services</p> <p>Out-of-network</p>
<ul style="list-style-type: none"> Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once every 12 months. 	<p>diseases and conditions of the eye</p> <p>\$0 copay for one glaucoma screening every 12 months</p>	<p>treat diseases and conditions of the eye</p> <p>20% of the cost for one glaucoma screening every 12 months</p>
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. (Coverage is at the Medicare Allowable rate. Contact your eye professional for assistance.) 	<p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery</p>	<p>20% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery</p>
<p>Our plan covers one routine eye exam every 12 months.</p>	<p>\$0 copay for one routine eye exam every 12 months</p>	<p>20% of the cost for one routine eye exam every 12 months</p>
<p> “Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>	<p>20% of the cost of the service</p>

2016 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

<p>Services that are covered for you</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Network</p>	<p>What you must pay (after deductible listed on page 1) when you get these services Out-of-network</p>
<p>appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>		

*Note: See Chapter 4, Section 2.1 of the *Evidence of Coverage* for information on prior authorization rules.

Aetna Life Insurance Company

Contract Holder Name: STATE OF MAINE

Contract Holder Group Agreement Effective Date: 01/01/2016

Contract Holder Number: 457677

This Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) is part of the *Evidence of Coverage* (EOC) for our plan. When the EOC refers to the attachment for details of Medicare Part D prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart. (See the EOC chapters titled “Using the plan’s coverage for your Part D prescription drugs” and “What you pay for your Part D prescription drugs.”)

Annual Deductible Amount per Member

\$0

Formulary Type:

State of Maine

Initial Coverage Limit:

\$3,310

True Out-of-Pocket Amount:

\$4,850

Retail Pharmacy Network: S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can look in your Pharmacy Directory, visit our website (<http://www.aetnaretireplans.com>), or call Customer Service (phone numbers are printed on the back of your member ID card).

Enhanced Drug Benefit

We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan, including the following:

- Drugs when used for weigh loss
- Drugs when used to promote fertility
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Drugs when used for the treatment of sexual or erectile dysfunction
- DESI drugs

The cost share for these drugs is listed in the table below. See Tier 1 for the Generic cost share amount and Tier 2 for the Brand cost share amount. **Drugs used for the treatment of sexual or erectile dysfunction, and agents when used to promote fertility can be accessed at a \$50 member cost share.** The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. Limitations, such as quantity limits and prior authorization requirements can be found in the formulary included in this mailing. In addition, if you are receiving “Extra Help” from Medicare to pay for your prescriptions, the “Extra Help” will not pay for these drugs. Please refer to your formulary or call Customer Service for more information.

Every drug on the plan’s Drug List is in one of the cost-sharing tiers described below:

- Tier One – Generic drugs
- Tier Two – Preferred brand drugs
- Tier Three – Non-preferred brand drugs

To find out which cost-sharing tier your drug is in, look it up in the plan’s Drug List. If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Initial Coverage Stage: Amount you pay, up to \$3,310 in total covered prescription drug expenses:

Three Tier Plan	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Standard retail or standard mail order cost-sharing (up to a 90-day supply)	Preferred mail order cost-sharing (up to a 90-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)
Tier 1 Generic drugs	\$10	\$10	\$10	\$10	\$10
Tier 2 Preferred brand drugs	\$30	\$30	\$30	\$30	\$30
Tier 3 Non-preferred brand drugs	\$45	\$45	\$45	\$45	\$45

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled “Using the plan’s coverage for your Part D prescription drugs,” Section 2.5.

Coverage Gap Stage: Amount you pay after you reach \$3,310 in total covered prescription drug expenses and until you reach \$4,850 in out-of-pocket covered prescription drug costs.

Your plan sponsor/former employer provides additional coverage during the Coverage Gap stage for covered drugs. This supplemental gap coverage is listed in the below chart:

Supplemental Gap Coverage Tiers	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Standard retail or standard mail order cost-sharing (up to a 90-day supply)	Preferred mail order cost-sharing (up to a 90-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)
Tier 1 Generic drugs	\$10	\$10	\$10	\$10	\$10
Tier 2 Preferred brand drugs	\$30	\$30	\$30	\$30	\$30

Supplemental Gap Coverage Tiers	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Standard retail or standard mail order cost-sharing (up to a 90-day supply)	Preferred mail order cost-sharing (up to a 90-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)
Tier 3 Non-preferred brand drugs	\$45	\$45	\$45	\$45	\$45

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled “Using the plan’s coverage for your Part D prescription drugs,” Section 2.5.

Your plan sponsor/former employer provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching \$4,850 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	You pay \$0

Step Therapy

Your plan includes step therapy. This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

The State of Maine Custom Formulary:

Your plan uses a Closed formulary, which means that only drugs on Aetna’s preferred drug list will be covered under your plan as long as the drug is medically necessary and the plan rules are followed. Non-preferred copayment levels may apply to some drugs on the preferred drug list. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2016 Group Formulary (List of Covered Drugs)* for more information.