Aetna Medicare Premier (PPO) offered by AETNA LIFE INSURANCE COMPANY

Annual Notice of Changes for 2021

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

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: December 31, 2021)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, 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 and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Aetna Medicare Premier (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Aetna Medicare Premier (PPO).
- If you join another plan by **December 7**, **2020**, your new coverage will start on **January 1**, **2021.** You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-800-282-5366 for additional information. (TTY users should call 711). Hours are 8 am to 8 pm, 7 days a week.
- This document may be made available in other formats such as braille, large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aetna Medicare Premier (PPO)

- Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.
- When this booklet says "we", "us", or "our", it means AETNA LIFE INSURANCE COMPANY. When it says "plan" or "our plan", it means Aetna Medicare Premier (PPO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Aetna Medicare Premier (PPO) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.aetnamedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. (See Section 1.1 for details.)	$29	$29
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $3,900 From network and out-of-network providers combined: $7,500	From network providers: $3,900 From network and out-of-network providers combined: $8,500
Doctor office visits	In-Network: Primary care visits: $0 copay per visit Specialist visits: $30 copay per visit Out-of-Network: Primary care visits: $20 copay per visit Specialist visits: $50 copay per visit	In-Network: Primary care visits: $0 copay per visit Specialist visits: $35 copay per visit Out-of-Network: Primary care visits: $20 copay per visit Specialist visits: $50 copay per visit
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.	In-Network: $250 per day, days 1-6; $0 per day, days 7-90; $0 copay for additional days Out-of-Network: 50% per stay	In-Network: $250 per day, days 1-6; $0 per day, days 7-90; $0 copay for additional days Out-of-Network: 50% per stay

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: *Preferred cost-sharing:* • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33% *Standard cost-sharing:* • Drug Tier 1: $15 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33%	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: *Preferred cost-sharing:* • Drug Tier 1: $0 • Drug Tier 2: $5 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33% *Standard cost-sharing:* • Drug Tier 1: $15 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33%

Annual Notice of Changes for 2021
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B Premium.)	$29	$29

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- 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. Please see Section 5 regarding "Extra Help" from Medicare.

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 generally pay nothing for covered services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,900	$3,900 Once you have paid $3,900 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.

Cost	2020 (this year)	2021 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,500	$8,500 Once you have paid $8,500 out-of-pocket for covered services, you will pay nothing for your covered 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 www.aetnamedicare.com/findprovider. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 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, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to 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 to manage 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.aetnamedicare.com/findpharmacy. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Acupuncture services for chronic low back pain	In-Network: You pay a $30 copay for each Medicare-covered service.	In-Network: You pay a $35 copay for each Medicare-covered service.
Additional telehealth services	Additional telehealth services are not covered.	You pay a $0-$45 copay for each service. Copays vary based on the type and rendering provider of telehealth services received.

Cost	2020 (this year)	2021 (next year)
Dental services	In-Network: Non-Medicare covered dental services allowance: Plan reimburses up to $1,000 every year for non-Medicare covered preventive dental services and non-Medicare covered comprehensive dental services combined. You do not have to use an in-network provider for your non-Medicare covered dental services. See the *Evidence of Coverage* for more information.	In-Network: Non-Medicare covered dental services allowance: Plan reimburses up to $1,250 every year for non-Medicare covered preventive dental services and non-Medicare covered comprehensive dental services combined. You do not have to use an in-network provider for your non-Medicare covered dental services. See the *Evidence of Coverage* for more information.
Diagnostic colonoscopies performed at ambulatory surgical centers	In-Network: You pay a $260 copay if a polyp is removed or biopsy is performed during a covered screening colonoscopy. If you have had polyps removed during a previous colonoscopy or have a prior history of colon cancer, ongoing colonoscopies are subject to outpatient surgery cost-sharing. See the *Evidence of Coverage* for more information.	In-Network: You pay a $0 copay if a polyp is removed or biopsy is performed during a covered screening colonoscopy. If you have had polyps removed during a previous colonoscopy or have a prior history of colon cancer, ongoing colonoscopies are subject to outpatient surgery cost-sharing. See the *Evidence of Coverage* for more information.

Cost	2020 (this year)	2021 (next year)
Diagnostic colonoscopies performed at hospital outpatient facilities	In-Network: You pay a $260 copay if a polyp is removed or biopsy is performed during a covered screening colonoscopy. If you have had polyps removed during a previous colonoscopy or have a prior history of colon cancer, ongoing colonoscopies are subject to outpatient surgery cost-sharing. See the *Evidence of Coverage* for more information.	In-Network: You pay a $0 copay if a polyp is removed or biopsy is performed during a covered screening colonoscopy. If you have had polyps removed during a previous colonoscopy or have a prior history of colon cancer, ongoing colonoscopies are subject to outpatient surgery cost-sharing. See the *Evidence of Coverage* for more information.
Diagnostic mammogram	In-Network: You pay a $10 copay for each Medicare-covered service.	In-Network: You pay a $0 copay for each Medicare-covered service.
Eye exams	In-Network: You pay a $0-$30 copay for each Medicare-covered service. The minimum cost share is for the initial diabetic eye exam each year. The maximum cost share is for all other Medicare-covered eye exams.	In-Network: You pay a $0-$35 copay for each Medicare-covered service. The minimum cost share is for the initial diabetic eye exam each year. The maximum cost share is for all other Medicare-covered eye exams.
Eye exams (follow up diabetic eye exams)	In-Network: You pay a $30 copay for each Medicare-covered service.	In-Network: You pay a $35 copay for each Medicare-covered service.

Cost	2020 (this year)	2021 (next year)
Hearing aids	Non-Medicare covered hearing aid maximum benefit allowance: Plan pays up to $1,000 per ear for hearing aids every year. Non-Medicare Covered hearing aid services are provided by Hearing Care Solutions. See the *Evidence of Coverage* for more information. Hearing aids: • $0 copay (two hearing aids every year)	Non-Medicare covered hearing aid maximum benefit allowance: Plan pays up to $500 per ear for hearing aids every year. Non-Medicare Covered hearing aid services are provided by NationsHearing. See the *Evidence of Coverage* for more information. Hearing aids: • $0 copay (two hearing aids every year)
Hearing exams	In-Network: You pay a $30 copay for each Medicare-covered service.	In-Network: You pay a $35 copay for each Medicare-covered service.
Help during a COVID-19 public health emergency	During the COVID-19 public health emergency, we offered temporarily expanded coverage, including broad coverage of telehealth services, zero dollar telehealth visits, PCP visits, and inpatient COVID testing.	If a COVID-19 public health emergency is in effect, members have additional coverage to help ensure care continuity and provide care in the home when appropriate. If a declaration is in effect, please reach out to Member Services at the number on the back of your ID card for more information.
Inpatient mental health care services	In-Network: You pay $1,763 per stay for each medically necessary covered inpatient mental health care stay.	In-Network: You pay $1,871 per stay for each medically necessary covered inpatient mental health care stay.

Cost	2020 (this year)	2021 (next year)
Lab services	Out-of-Network: You pay a $20 copay for each Medicare-covered service.	Out-of-Network: You pay a $15 copay for each Medicare-covered service.
Other health care professional services	In-Network: You pay a $0-$30 copay for each Medicare-covered service. The minimum cost share is for services provided by your primary care physician in their office. The maximum cost share is for services performed by a provider other than your primary care physician.	In-Network: You pay a $0-$35 copay for each Medicare-covered service. The minimum cost share is for in-home assessments. The maximum cost share is for services provided by a specialist.
Outpatient dialysis services	In-Network: You pay 0%-20% of the total cost for each Medicare-covered service. The minimum cost share is for self-dialysis training. The maximum cost share is for outpatient dialysis, certain home support services and home dialysis equipment and supplies.	In-Network: You pay 20% of the total cost for each Medicare-covered service.
Outpatient dialysis services	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.
Outpatient hospital observation services	In-Network: You pay a $30 copay for each Medicare-covered service.	In-Network: You pay a $250 copay for each Medicare-covered service.

Cost	2020 (this year)	2021 (next year)
Over-the-Counter (OTC) items	Plan provides an allowance of $40 every month for Over-the-Counter (OTC) medications and supplies which can be ordered through a catalog. You may place one order each month and are limited to up to five (5) like items per month, with the exception of Blood Pressure Monitors, which are limited to one per year. Orders cannot exceed your monthly allowance.	Plan provides an allowance of $90 every three months for Over-the-Counter (OTC) medications and supplies which can be ordered through a catalog. Please visit www.cvs.com/otchs/myorder and log into your account to view your catalog of Over-the-Counter (OTC) items available to you. You may place up to three orders each quarter and are limited to up to nine (9) like items per quarter (every three months), with the exception of Blood Pressure Monitors, which are limited to one per year. Orders cannot exceed your quarterly allowance.
Physician specialist services	In-Network: You pay a $30 copay for each Medicare-covered service.	In-Network: You pay a $35 copay for each Medicare-covered service.
Podiatry services	In-Network: You pay a $30 copay for each Medicare-covered service.	In-Network: You pay a $35 copay for each Medicare-covered service.
Skilled nursing facility (SNF) services	In-Network: $0 per day, days 1-20; $178 per day, days 21-100	In-Network: $0 per day, days 1-20; $184 per day, days 21-100
Urgently needed care services	You pay a $65 copay for each Medicare-covered service.	You pay a $45 copay for each Medicare-covered service.

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 provided electronically.

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 Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*. During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

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

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- You and your doctor can ask the plan to make an exception for you and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* which is located on our website at www.aetnamedicare.com. 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. A transition supply will be provided to you at the point-of-sale with exceptions where certain drugs require coverage determination whether it should be covered under Medicare Part B or Part D benefit. In such case, it might require your doctor or pharmacy to provide additional information; therefore, the issue may not be resolved at point-of-sale.

- If you are a currently enrolled member who does not request an exception before January 1, 2021, and your current Part D eligible drug therapy coverage is negatively impacted by a formulary change, we will cover up to a 30-day temporary supply of the drug starting on January 1st.
- 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 (at least 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* which is located on our website at www.aetnamedicare.com, if you need to continue on the current drug.

Important Note: Please take action on working with your doctor to find appropriate alternatives covered in the next plan year before January 1st. 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* which is located on our website at www.aetnamedicare.com. Look for Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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 costs.

Because you receive "Extra Help" and haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider."

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 in your Summary of Benefits or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (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	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply at a network pharmacy:	Your cost for a one-month supply at a network pharmacy:
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of the *Evidence of Coverage.*	**Tier 1 Preferred Generic:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $15 per prescription.	**Tier 1 Preferred Generic:** *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $15 per prescription.

Stage	2020 (this year)	2021 (next year)
	Tier 2 Generic: *Preferred cost-sharing:* You pay $0 per prescription. *Standard cost-sharing:* You pay $20 per prescription.	**Tier 2 Generic:** *Preferred cost-sharing:* You pay $5 per prescription. *Standard cost-sharing:* You pay $20 per prescription.
	Tier 3 Preferred Brand: *Preferred cost-sharing:* You pay $47 per prescription. *Standard cost-sharing:* You pay $47 per prescription.	**Tier 3 Preferred Brand:** *Preferred cost-sharing:* You pay $47 per prescription. *Standard cost-sharing:* You pay $47 per prescription.
	Tier 4 Non-Preferred Drug: *Preferred cost-sharing:* You pay $100 per prescription. *Standard cost-sharing:* You pay $100 per prescription.	**Tier 4 Non-Preferred Drug:** *Preferred cost-sharing:* You pay $100 per prescription. *Standard cost-sharing:* You pay $100 per prescription.
	Tier 5 Specialty: *Preferred cost-sharing:* You pay 33% of the total cost. *Standard cost-sharing:* You pay 33% of the total cost.	**Tier 5 Specialty:** *Preferred cost-sharing:* You pay 33% of the total cost. *Standard cost-sharing:* You pay 33% of the total cost.
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.	Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages - the Coverage Gap Stage and the Catastropic Coverage Stage

- are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For more information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Aetna Medicare Premier (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Aetna Medicare Premier (PPO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see **Addendum A** at the back of the *Evidence of Coverage*), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, AETNA LIFE INSURANCE COMPANY offers other Medicare health 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 Aetna Medicare Premier (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Aetna Medicare Premier (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:

- Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 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 3 Deadline for Changing Plans

If you want to change to a different 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, 2021.

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

In certain 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, those who have or are leaving employer coverage, and those who move out of the service area may be 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 enrolled in a Medicare Advantage Plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets 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 5 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 am and 7 pm, 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 a program called the State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. 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 ADAP for your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP for your state (the name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage*).

SECTION 6 Questions?

Section 6.1 – Getting Help from Aetna Medicare Premier (PPO)

Questions? We're here to help. Please call Member Services at 1-800-282-5366. (TTY only, call 711.) We are available for phone calls 8 am to 8 pm, 7 days a week. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for Aetna Medicare Premier (PPO). 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 located on our website at www.aetnamedicare.com. You may also call Member Services

to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.aetnamedicare.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – 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 (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 www.medicare.gov/plan-compare.)

Read *Medicare & You 2021*

You can read *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (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.

See the *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Out-of-network/non-contracted providers are under no obligation to treat Aetna Medicare members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

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

Aetna Medicare's pharmacy network includes limited lower cost, preferred pharmacies in: Rural Nebraska, Rural Kansas, Suburban West Virginia, Rural Maine, Suburban Arizona, Rural Michigan, and Urban Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call the number on your ID card (TTY: 711) or consult the online pharmacy directory at www.aetnamedicare.com/findpharmacy.

Members who get "Extra Help" are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website at or call the phone number listed in this material.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe that Aetna Medicare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Aetna Medicare Grievances , PO Box 14067, Lexington, KY 40512. You can also file a grievance by phone by calling the phone number on your member identification card (TTY: 711). If you need help filing a grievance, the Aetna Medicare Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

繁體中文（**CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。