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 2018 Drug List and 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 & Pharmacy Directory.

2. **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?
2. **COMPARE:** Learn about other plan choices - Your coverage is offered through your former employer/union/trust.

   It is important that you carefully consider your decision before changing your group retiree coverage. This is important because you may permanently lose benefits you currently receive under your former employer/union/trust retiree group coverage if you switch plans.

   - Contact your benefits administrator to see if there are other options are available.
   - Check coverage and costs of individual Medicare health plans in your area.
   - Review the list in the back of your Medicare & You handbook.
   - Look in Section 4.2 to learn more about your choices.

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

   - If you want to keep 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.
   - You can change your coverage during your former employer/union/trust’s 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. As a member of a group Medicare plan, you are eligible for a special enrollment period if you leave your former employer/union/trust’s plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time. Look in Section 3.2 to learn more about your choices.

4. **ENROLL:** To change plans, call the benefits administrator of your former employer or retiree group for information.
Additional Resources

- This document is available for free in Spanish.
- Please contact Customer Service at the telephone number on your Aetna member ID card or call our general customer service center at 1-888-267-2637 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.
- 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.
- Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement.** Please visit the Internal Revenue Service (IRS) website at [https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families](https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual requirement for MEC.

About Aetna Medicare Plan (PPO)

- Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. 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).
### Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 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* and *Schedule of Cost Sharing* (SOC) to see if other benefit or cost changes affect you.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Combined In- and Out-of-Network Deductible:</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amounts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From network providers:</td>
<td><strong>$2,500</strong></td>
<td><strong>$2,750</strong></td>
</tr>
<tr>
<td>From in-network and out of network providers combined:</td>
<td><strong>$2,500</strong></td>
<td><strong>$2,750</strong></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a <strong>$10</strong> copay per visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a <strong>$25</strong> copay per visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-network:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay <strong>20%</strong> of the total cost.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay <strong>20%</strong> of the total cost.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>2017 (this year)</td>
<td>2018 (next year)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>In-Network: 0% per stay</td>
<td>In-Network: 0% per stay</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: 20% per stay</td>
<td>Out-of-network: 20% per stay</td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td>Deductible: No Deductible</td>
<td>Deductible: No Deductible</td>
</tr>
<tr>
<td>For a one-month (30-day) supply of a drug that is filled at a network pharmacy that provides standard cost-sharing. The list of covered drugs associated with your plan will change for 2018. Please confirm that your drugs are still covered and make arrangements before January 1 to prevent disruption in coverage.</td>
<td>Copays during the Initial Coverage Stage: Generic: $10 Preferred Brand: $25 Non-Preferred Brand: $40</td>
<td>Copays during the Initial Coverage Stage: Generic: $10 Preferred Brand: $25 Non-Preferred Brand: $40 Specialty: $55</td>
</tr>
</tbody>
</table>
# Annual Notice of Changes for 2018

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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 a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

If Aetna bills you directly for your total plan premium, we will mail you a monthly invoice or annual coupon book detailing your premium amount.

You must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.

- 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.

#### 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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-network maximum out-of-pocket amount</strong></td>
<td>$2,500</td>
<td>$2,750</td>
</tr>
</tbody>
</table>

Your costs for covered medical services (such as copays, coinsurance, and deductibles, if applicable) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium (if applicable) and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.

Once you have paid $2,750 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 | 2017 (this year) | 2018 (next year)
--- | --- | ---
Combined maximum out-of-pocket amount | $2,500 | $2,750

Once you have paid $2,750 out-of-pocket for covered services, you will pay nothing for your covered services from in-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 & Pharmacy Directory is located on our website at http://www.aetnamedicaredocfind.com. Please call Customer Service at the telephone number on your Aetna member ID card or contact our general customer service center at 1-888-267-2637. (For TTY assistance please dial 711.) You may also call Customer Service for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **Please review the 2018 Provider & Pharmacy 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.
- 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 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. Please review the **2018 Provider & Pharmacy Directory to see which pharmacies are in our network**. Page 1 of your Prescription Drug Schedule of Cost Sharing lists the name of your 2018 pharmacy network. Please refer to this network name when looking for 2018 network pharmacies. The Prescription Drug Schedule of Cost Sharing is enclosed in this packet.

An updated Provider & Pharmacy Directory is located on our website at [https://www.aetnamedicare.com/findpharmacy](https://www.aetnamedicare.com/findpharmacy). You may also call Customer Service for updated pharmacy information or to ask us to mail you a Provider & Pharmacy Directory.

### 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 the 2018 Schedule of Cost Sharing included in this package.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes self-management training, diabetic services and supplies</strong></td>
<td>In-Network: You pay 0% of the total cost of the diabetic service and supply.</td>
<td>In-Network: You pay 0% of the total cost of the diabetic service and supply.</td>
</tr>
<tr>
<td></td>
<td>Urine test strips were not covered.</td>
<td>You pay 0% of the total cost for urine test strips.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: You pay 20% of the total cost of the diabetic service and supply.</td>
<td>Out-of-network: You pay 0% of the total cost of the diabetic service and supply.</td>
</tr>
<tr>
<td></td>
<td>You pay 20% of the total cost for Medicare-covered diabetes self-management training.</td>
<td>You pay 0% of the total cost for urine test strips.</td>
</tr>
<tr>
<td><strong>Emergency care</strong></td>
<td>In-Network: You pay a $75 copay per service.</td>
<td>In-Network: You pay a $100 copay per service.</td>
</tr>
<tr>
<td>Coverage is available worldwide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>2017 (this year)</td>
<td>2018 (next year)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Out-of-network:</td>
<td>You pay a $75 copay per service.</td>
<td>Out-of-network: You pay a $100 copay per service.</td>
</tr>
<tr>
<td>Health and wellness education programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Healthy Lifestyle Coaching Program</td>
<td>Covered</td>
<td>Healthy Lifestyle Coaching Program is not covered</td>
</tr>
<tr>
<td>Medicare Part B prescription drugs - Allergy shots</td>
<td>Out-of-network: You pay 20% of the total cost per allergy shot.</td>
<td>Out-of-network: You pay 0% of the total cost per allergy shot.</td>
</tr>
<tr>
<td>Self-dialysis training services and kidney disease education</td>
<td>In-Network: You pay a $10 copay per service received from your PCP.</td>
<td>In-Network: You pay a $0 copay for self-dialysis training and kidney disease education.</td>
</tr>
<tr>
<td></td>
<td>You pay a $25 copay per service received from other providers.</td>
<td></td>
</tr>
<tr>
<td>Specialist visit – allergy testing</td>
<td>Out-of-network: 20% of the cost for Medicare-covered allergy testing.</td>
<td>Out-of-network: 0% of the cost for Medicare-covered allergy testing.</td>
</tr>
<tr>
<td>Enhanced benefit - cervical and vaginal cancer screening - (Non-Medicare covered)</td>
<td>Non-Medicare-covered Pap and pelvic exams are not covered.</td>
<td>In-Network: You pay 0% of the total cost for Non-Medicare-covered Pap and pelvic exams. We cover one exam every 12 months.</td>
</tr>
</tbody>
</table>
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 Member Services 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 of a non-formulary drug in the first 90 days of the plan year or 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 3, Section 5.2 of the Evidence of Coverage.) After you get this temporary supply, you should talk with your doctor to decide what to do when your temporary supply runs out. Here are your options:

- **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)).

You can ask for an exception for Part D drugs that are not on the formulary. You can also ask for an exception for Part D drugs that are on our formulary but with a restriction, such as prior authorization, step therapy, or quantity limit.

If you are currently taking a Part D drug that will no longer be on the formulary as of January 1, 2018, or a Part D drug that will have new restrictions on it beginning on January 1st, you can ask for an exception before that date to make sure we will continue covering that drug. Here is what will happen if you do not request an exception for those drugs before January 1, 2018:

- If the Part D drug you are taking will no longer be on the formulary or will have a restriction beginning January 1, 2018, we will cover up to a 30-day temporary supply (unless your prescription is written for fewer days) of the Part D drug for the first 90 days of the new plan year starting on January 1st.
• If you live in a long-term care facility and the Part D drug you are taking will no
longer be on the formulary or will have a restriction beginning January 1, 2018, we
will allow you to refill your prescription until we have provided you with at least a
91-day supply and up to a 98-day 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 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 (up to a 30-day supply) for the applicable drug(s).

Regardless of the reason you received a temporary supply, you will need to utilize our exception
process if you need to continue on the current drug.

Important Note: Please take advantage of filing your exception requests before January 1st. It
will make for a very easy transition into the next calendar year. 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 7 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 send 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. If you receive “Extra Help” and haven’t received this insert by
September 30, 2017, 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

<table>
<thead>
<tr>
<th>Stage</th>
<th>2017 (this year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
<tr>
<td></td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>
Changes to Your Cost-sharing in the Initial Coverage Stage

Your cost-sharing in the initial coverage stage for certain tier drugs may be changing from copayment to coinsurance or coinsurance to copayment. Please see the following chart for the changes from 2017 to 2018.

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.

<table>
<thead>
<tr>
<th>Stage</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2: Initial Coverage Stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During this stage, the plan pays its</td>
<td>Your cost for a one-month supply</td>
<td>Your cost for a one-month supply</td>
</tr>
<tr>
<td>share of the cost of your drugs and</td>
<td>filled at a network pharmacy:</td>
<td>filled at a network pharmacy:</td>
</tr>
<tr>
<td>you pay your share of the cost.</td>
<td>Standard cost-sharing</td>
<td>Standard cost-sharing</td>
</tr>
<tr>
<td>The costs in this row are for a one-month</td>
<td>Generic: $10</td>
<td>Generic: $10</td>
</tr>
<tr>
<td>(30-day) supply when you fill your</td>
<td>Preferred Brand: $25</td>
<td>Preferred Brand: $25</td>
</tr>
<tr>
<td>prescription at a network pharmacy that</td>
<td>Non-Preferred Brand: $40</td>
<td>Non-Preferred Brand: $40</td>
</tr>
<tr>
<td>provides standard cost-sharing. For</td>
<td></td>
<td>Specialty: $55</td>
</tr>
<tr>
<td>information about the costs for a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>long-term supply or for mail-order</td>
<td>Once your total drug costs have</td>
<td>Once your total drug costs have</td>
</tr>
<tr>
<td>prescriptions, look in the 2018 Prescription Drug Schedule of Cost Sharing included in this packet.</td>
<td>reached $3,700, you will move to the next stage (the Coverage Gap Stage).</td>
<td>reached $3,750, you will move to the next stage (the Coverage Gap Stage).</td>
</tr>
</tbody>
</table>

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.

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 2018 Prescription Drug Schedule of Cost Sharing included in this packet.

SECTION 2 Administrative Changes

<table>
<thead>
<tr>
<th>Process</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax number for Medical</td>
<td>1-860-975-9631</td>
<td>1-724-741-4953</td>
</tr>
<tr>
<td>Appeals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SECTION 3 Deciding Which Plan to Choose**

**Section 3.1 – If you want to stay in Aetna Medicare Plan (PPO)**

Your benefits administrator will tell you if you need to do anything to stay enrolled in your Aetna Medicare Plan.

**Section 3.2 – If you want to change plans**

We hope to keep you as a member. However, if you want to change your plan, here are your options:

**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.
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 former employer/union/trust retiree group coverage if you switch plans. Call the benefits administrator of your former employer or retiree group for information.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2018, 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 https://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 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.

**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 former employer/union/trust’s plan. This means that you can enroll in an individual Medicare health plan or Original Medicare at any time during the year.

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 former employer/union/trust retiree group coverage if you switch plans. Call the benefits administrator of your former employer or retiree group for information.
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:
  o 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  o 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
  o 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 telephone number on your Aetna member ID card or call our general customer service center at 1-888-267-2637. (TTY only, call 711.) We are available for phone calls 8 a.m. to 6 p.m. local time, Monday through Friday. Calls to these numbers are free.

Read your 2018 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 2018. For details about your plan, look in the 2018 Evidence of Coverage and the Schedule of Cost Sharing. 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. The Schedule of Cost Sharing lists the out of pocket cost share for your plan, a copy is included in this envelope.

Visit our Website

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

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 (https://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 https://www.medicare.gov and click on “Find health & drug plans.”)

Read Medicare & You 2018

You can read Medicare & You 2018 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 (https://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.