Aetna Medicare Plan (PPO) offered by Aetna Medicare

Annual Notice of Changes for 2022

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.*

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 2022 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 https://go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. 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.

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☐ 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 – Your coverage is offered through your former employer/union/trust

   It is important that you carefully consider your decision before changing your 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 plan benefits administrator to see if there are other options available.

☐ Check coverage and costs of individual Medicare health 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 2022* handbook.
- Look in Section 2.2 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 2.2 to learn more about your choices.

4. **ENROLL:** To change plans, call your plan benefits administrator for information

Additional Resources

- This document is available for free in Spanish
- Este documento está disponible sin cargo en español
- Please contact our Member Services at the telephone number on your member ID card or call our general Member Services at 1-888-267-2637 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 9 p.m. ET, Monday through Friday.
- This document may be available in other formats such as braille, large print or other alternate formats. Please contact Member Services for more information.
- **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 Plan (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 Medicare. When it says "plan" or "our plan," it means Aetna Medicare Plan (PPO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Aetna Medicare Plan (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 AetnaRetireePlans.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Deductible	**No Deductible**	**No Deductible**
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network and out-of-network providers combined: **$1,500**	From network and out-of-network providers combined: **$1,500**
Doctor office visits	Primary care visits: **$10** copay per visit. Specialist visits: **$35** copay per visit.	Primary care visits: **$10** copay per visit. Specialist visits: **$35** 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.	**$500 per stay**	**$500 per stay**

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: **No Deductible** Standard retail cost sharing for a 30-day supply during the Initial Coverage Stage: **Generic:** You pay $10 **Preferred Brand:** You pay $20 **Non-Preferred Brand:** You pay $35 **Specialty:** You pay $35	Deductible: **No Deductible** Standard retail cost sharing for a 30-day supply during the Initial Coverage Stage: **Generic:** You pay $10 **Preferred Brand:** You pay $20 **Non-Preferred Brand:** You pay $35 **Specialty:** You pay $35

Annual Notice of Changes for 2022

Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Your coverage is provided through a contract with your former employer/union/trust. Your 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 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 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 Amount

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	2021 (this year)	2022 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles, if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) and your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	**$1,500**	**$1,500** Once you have paid $1,500 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 Directory* is located on our website at AetnaRetireePlans.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *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. The *Prescription Drug Schedule of Cost Sharing* lists the name of your 2022 pharmacy network. Please refer to this network name when looking for 2022 network pharmacies. *The Prescription Drug Schedule of Cost Sharing* is enclosed in this packet.

There are changes to our network of pharmacies for next year. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network.** An updated *Pharmacy Directory* is located on our website at AetnaRetireePlans.com. You may also call Member Services for updated pharmacy information or to ask us to mail you a *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 *2022 Schedule of Cost Sharing* included in this package.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing

- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Home infusion therapy professional services	You pay a $35 copay for each Medicare-covered service.	You pay a $0 copay for each Medicare-covered service performed by a home health care provider. You pay a $10 copay for each Medicare-covered service performed by a primary care physician. You pay a $35 copay for each Medicare-covered service performed by a specialist.
Lab services	You pay a $35 copay for each Medicare-covered lab service.	You pay a $35 copay for each Medicare-covered lab service. You pay a $0 copay for certain Medicare-covered lab services including Hemoglobin A1c, Urine Protein, Prothrombin (Protime), Urine Albumin, and Fecal immunochemical test (FIT).
Telehealth additional services - primary care physician (PCP)	You pay a $10 copay for each primary care physician service.	You pay a $10 copay for each primary care physician service. If the service is performed by Teladoc, you pay a $0 copay for each service.
Telehealth additional services - physician specialist	Additional telehealth services were covered during the public health emergency.	You pay a $35 copay for each additional telehealth specialist service.

Cost	2021 (this year)	2022 (next year)
Transportation services (non-emergency transportation that is not covered by Medicare)	Transportation services (non-emergency) are not covered.	You pay a $0 copay for each non-Medicare covered trip. • 24 one-way trips to and from plan-approved locations each year • Trips must be within 60 miles of provider location.

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.
  - 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 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 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 AetnaRetireePlans.com. Look for Chapter 9, Section 6 (*Your Part D prescription drugs: How to ask for a coverage decision or make an appeal)*.

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, 2022, 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 (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 action on working with your doctor to find appropriate alternatives or to file 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* which is located on our website at AetnaRetireePlans.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" if you haven't received this insert by September 30, 2021, 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 the enclosed *Prescription Drug Schedule of Cost Sharing*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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

Your cost sharing in the initial coverage stage may be changing from copayment to coinsurance *or* coinsurance to copayment. Please see the following chart for the changes from 2021 to 2022.

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	2021 (this year)	2022 (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.** 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 *2022 Prescription Drug Schedule of Cost Sharing* included in this packet. 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.	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** Generic: You pay $10 Preferred Brand: You pay $20 Non-Preferred Brand: You pay $35 Specialty: You pay $35 Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** Generic: You pay $10 Preferred Brand: You pay $20 Non-Preferred Brand: You pay $35 Specialty: You pay $35 Once your total drug costs have reached $4,430, 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 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 2022 *Prescription Drug Schedule of Cost Sharing* included in this packet.

SECTION 2 Deciding Which Plan to Choose

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

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

Section 2.2 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 timely. 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

It is important that you carefully consider your decision before changing your 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 your plan benefits administrator for information.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), 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.**

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 Plan (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 Plan (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

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 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 changing your 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 your plan benefits administrator for information.

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 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 Plan (PPO)

Questions? We're here to help. Please call Member Services at the telephone number on your member ID card or call our general Member Services at 1-888-267-2637. (TTY only, call 711.) We are available for phone calls 8 a.m. to 9 p.m. ET, Monday through Friday. Calls to these numbers are free.

Read your 2022 *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 2022.

For details, look in the 2022 *Evidence of Coverage* and the *Schedule of Cost Sharing* for Aetna Medicare Plan (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 AetnaRetireePlans.com. The *Schedule of Cost Sharing* lists the out-of-pocket cost share for your plan; a copy is included in this envelope. 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 AetnaRetireePlans.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 2022*

You can read the *Medicare & You 2022* 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 members, except in emergency situations. Please call our Member Services 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.

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 does 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, call the phone number listed in this material or the phone number on your benefit ID card.

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 Service at the phone number on your benefit ID card.

If you believe that we have 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 our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

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。