Emeriti®
Retirement Health

aetna®

Aetna's group retiree health insurance available through your Emeriti Retirement Healthcare Savings Plan

Three Medicare Advantage PPO plans

Three Medicare Part D prescription drug plans

One optional dental plan

A PPO is a preferred provider organization plan. A PPO plan with an extended service area (ESA) gives you the flexibility to see any provider, in or out of network, at the same cost. They just have to be licensed, eligible to receive Medicare payments and willing to accept your plan.

Visit **Aetna.com** or **Medicare.gov** to find a doctor or hospital in your area.

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2021 Aetna retiree medical plans – what you pay

Annual Maximum Out-of-pocket Amount
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.

Preventive Care
Includes annual wellness exam, routine physicals, Medicare covered immunizations, routine GYN Care, routine mammograms, routine prostate Cancer screening exam, routine colorectal Cancer screening, routine bone mass measurement, Medical Diabetes Prevention Program, routine eye exams, and routine hearing screening.

Primary Care Physician Visits
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.

Plan Features
Annual Plan Deductible
Annual Maximum Out-of-pocket Amount
Referral Requirement
Preventive Care
Primary Care Physician Visits
Physician Specialist Visits
Diagnostic Services/Labs/X-ray/Imaging
Routine Hearing Exam
Non-routine Hearing Services
Routine Vision Exam
Non-routine Vision Services
Urgently Needed Care
Emergency Care
Ambulance Services
Inpatient Hospital Care
Outpatient Surgery
Blood

Medicare Advantage PPO/ESA PREMIUM PLAN (no networks)	Medicare Advantage PPO PLUS PLAN	Medicare Advantage PPO STANDARD PLAN
$0	$0 in- and out-of-network	$0 in- and out-of-network
$2,000	$2,750 in-network; $5,500 out-of-network	$6,700 in-network; $10,000 out-of-network
None	None in- and out-of-network	None in- and out-of-network
$0	$0 in-network; 25% out-of-network	$0 in-network; 30% out-of-network
$15	15% in-network; 25% out-of-network	$15 in-network; 30% out-of-network
$15	15% in-network; 25% out-of network	$40 in-network; 30% out-of-network
$15	15% in-network; 25% out-of-network	$35 basic x-ray and $200 complex imaging, in-network 30% out-of-network
$0	$0	$0
$15	15% in-network; 25% out-of-network	$40 in-network; 30% out-of-network
$0	$0	$0
$15	15% in-network; 25% out-of-network	$40 in-network; 30% out-of-network
$15	$35 in- and out-of-network	$50 in- and out-of-network
$50, waived if admitted	$50, waived if admitted, in- and out-of-network	$75, waived if admitted, in- and out-of-network
$15	15% in-network; 25% out-of-network	$100 in-network; 30% out-of-network
$0, no day limit	$500 per admission No day limit, in-network 25% per admission No day limit, out-of-network	$200 per day (days 1-7) Plan pays 100% thereafter, no day limit, in-network 30% per admission, no day limit, out-of-network
$0	15% in-network; 25% out-of-network	$185 in-network; 30% out-of-network
Covered beginning with the first pint	Covered beginning with the first pint, in- and out-of-network	Covered beginning with the first pint, in- and out-of network

continued

2021 Aetna retiree medical plans – what you pay

Plan Features
Skilled Nursing Care
Days 1-20
Days 21-100
Days 100+
Outpatient Rehabilitation Services/Physical Therapy
Home Health Agency Care
Hospice Care
Chiropractic Services
Cardiac Rehabilitation Services
Pulmonary Rehabilitation Services
Inpatient Mental Healthcare
Outpatient Mental Health and Substance Abuse Treatment
Durable Medical Equipment/Prosthetic Devices
Podiatry Services
Diabetic Supplies
Outpatient Dialysis Treatments
Medicare Part B Drugs
Hearing Aid Reimbursement

[1] A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Medicare Advantage PPO/ESA PREMIUM PLAN (no networks)	Medicare Advantage PPO PLUS PLAN	Medicare Advantage PPO STANDARD PLAN
$0	0% in-network; 25% out-of-network	$0 in-network; 30% out-of-network
$75/day	15% in-network; 25% out-of-network	$125/day in-network; 30% out-of-network
Limited to 100 days per benefit period[1]	Limited to 100 days per benefit period[1] in- and out-of-network	Limited to 100 days per benefit period[1] in- and out-of-network
$15	15% in-network; 25% out-of-network	$40 in-network; 30% out-of-network
0%	0% in-network; 25% out-of-network	0% in-network; 30% out-of-network
Covered by Original Medicare at a Medicare certified hospice	Covered by Original Medicare at a Medicare certified hospice in- and out-of-network	Covered by Original Medicare at a Medicare certified hospice in- and out-of-network
$15	15% in-network; 25% out-of-network	$20 in-network; 30% out-of-network
$15	15% in-network; 25% out-of-network	$40 in-network; 30% out-of-network
$15	15% in-network; 25% out-of-network	$30 in-network; 30% out-of-network
$0 per stay	$500 per stay, in-network; 25% per say, out-of-network	$200 copay per day, day(s) 1-7 in-network 30% per stay out-of-network
$15	15% in-network; 25% out-of-network	$40 in-network; 30% out-of-network
15%	15% in-network; 25% out-of-network	20% in-network; 30% out-of-network
$15	15% in-network; 25% out-of-network	$40 in-network; 30% out-of-network
$0	$0 in-network, using Aetna's preferred vendor, in- and out-of-network. Contact Aetna for details.	$0 in-network, using Aetna's preferred vendor., in- and out-of-network. Contact Aetna for details.
$15	15% in-network; 15% out-of-network	20% in-network; 20% out-of-network
$0	0% in-network; 25% out-of-network	$0 in-network; 30% out-of-network
$1,000 every 36 months	$1,000 every 36 months, in- and out-of-network	$1,000 every 36 months, in- and out-of-network

2021 Aetna Medicare Part D prescription drug plans – what you pay

Benefit Features	Rx Premium Plan	Rx Plus Plan	Rx Standard Plan
Formulary	Open 2 Plus	Open 2 Plus	GRP B2
Annual deductible	$100	$200	$435
Initial Coverage Limit: $4,130 (Applies to retail, up to a 30- and 90-day supply, and mail-order supply)			
Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-preferred Brand	15% 25% 40%	15% 25% 50%	15% 25% 25%
Coverage Gap Phase begins after you reach Initial Coverage Limit of $4,130 and until you reach $6,550 in drug expenses (Applies to retail, up to a 30- and 90-day supply, and mail-order supply)			
Tier 1 – Generic Tier 2 – Preferred Brand Tier 3 – Non-preferred Brand	15% 25% 25%	15% 25% 25%	25% 25% 25%
Catastrophic Coverage Phase			
Catastrophic Coverage benefits start once $6,550 in true out-of-pocket costs is incurred	You pay $0	Greater of 5% of the cost of the drug – or $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs	Greater of 5% of the cost of the drug – or $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs
Step therapy[1]	Not required	Required for some drugs	Required for some drugs
Prior authorization[2]	Required for some drugs	Required for some drugs	Required for some drugs

[1] Step Therapy is a process where in certain cases one or more clinically equivalent drugs must be tried before the prescribed drug can be covered. If the step therapy drug does not work, Aetna can then cover the requested drug.

[2] Aetna requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Aetna before you fill your prescriptions. If you don't get approval, Aetna may not cover the drug.

2021 Aetna dental plan

Plan Features	How Plan Works
Annual deductible[1]	You pay $100
Preventive services	Plan pays 100%
Basic services	Plan pays 50%
Major services	Plan pays 50%
Annual benefit maximum paid by plan	$2,000
Office visit copay	$0
Orthodontic services	Not covered
Partial List of Plan Provisions	**What Plan Pays**
Preventive[2]	
Oral exams	100%
Cleanings, scalings, polishing	100%
Flouride	100%
Sealants (permanent molars only)	100%
Bitewing X-rays	100%
Full mouth series X-rays	100%
Basic	
Amalgam (silver) fillings	50%
Composite fillings (anterior teeth only)	50%
Stainless steel crowns	50%
Scaling and root planing[2]	50%
Gingivectomy	50%
Incision and drainage of abscess	50%
Uncomplicated extractions	50%
Surgical removal of erupted tooth	50%
Major[3]	
Root canal therapy, anterior/bicuspid teeth, with X-rays and cultures	50%
Root canal therapy, molar teeth, with X-rays and cultures	50%
Osseous surgery[2]	50%
Surgical removal of impacted tooth (partial bony/full bony)	50%
General anesthesia/intravenous sedation	50%
Inlays/onlays	50%
Crowns	50%
Full and partial dentures and denture repairs	50%
Pontics	50%

[1] The deductible applies to basic and major services only.

[2] Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate or evidence of coverage.

[3] Twelve month waiting period applies, but may be waived with evidence of continuing coverage.

NOTES: One-time only opt-in opportunity. Dental plan is community rated. Dental is only available when you enroll in a combination Medical/Rx coverage, or elect the stand-alone Rx Standard Plan. The dental plan is not available in Maryland.

The full name of Emeriti Retirement Health Solutions is The Emeriti Consortium for Retirement Health Solutions, an Illinois Nonprofit Corporation. Emeriti Retirement Health Solutions is not an insurance company, insurance broker or insurance provider. The Emeriti Program is delivered in collaboration with TIAA, CBIZ RPS, Aetna Life Insurance Company, and HealthPartners. Emeriti, TIAA, CBIZ RPS, Aetna Life Insurance Company, and HealthPartners are independent corporations and are not legally affiliated.

Aetna Medicare is an HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

This information is not a complete description of benefits. Call **1-800-307-4830 (TTY: 711)** for more information.

Every year, Medicare evaluates plans based on a 5-star rating system.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7 to 14 days. You can call the phone number on your member ID card if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Out-of-network/non-contracted providers are under no obligation to treat Aetna 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.

See 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.

Participating physicians, hospitals and other healthcare providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

Important information about your enrollment in a Medicare Advantage plan

As an Aetna Medicare member, you agree to the following:

I will need to keep my Medicare Parts A and B and continue to pay my Part B premium. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform Aetna of any prescription drug coverage that I have or may get in the future.

I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the calendar year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, during the Annual Enrollment Period, which is October 15–December 7 of every year), or under certain special circumstances.

The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that the Aetna Medicare Advantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I am a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare Advantage plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements.

I understand that beginning on the date the Aetna Medicare Advantage plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the Aetna Medicare Advantage plan provides refunds for all covered benefits, even if I get services out of network.

Services authorized by the Aetna Medicare Advantage plan and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with the Aetna Medicare Advantage plan, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan.

Release of information

By joining this Medicare health plan, I acknowledge that the Aetna Medicare Advantage plan will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that the Aetna Medicare Advantage plan will release my information, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be disenrolled from the plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the phone number listed in this material.

If you believe that Aetna 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 Grievance Department, P.O. Box 14067, Lexington, KY 40512. You can also file a grievance by phone by calling the phone number listed in this material. If you need help filing a grievance, call the phone number listed in this material. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**. You can also contact the Aetna Civil Rights Coordinator by phone at **1-855-348-1369**, by email at **MedicareCRCoordinator@aetna.com**, or by writing to Aetna Medicare Grievance Department, ATTN: Civil Rights Coordinator, P.O. Box 14067, Lexington, KY 40512. Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Important Dental PPO Information

Under the Dental® Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care at negotiated rates. Nonparticipating dentists will only be paid based on the standard negotiated rate provided to participating general dentists in the same geographical area.

Emergency Dental Care
When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Covered emergency services may vary, based on state law.

Some Services Not Covered Under the Plan Are:

1. Services or supplies that are covered in whole or in part: (a) under any other part of this Dental Care Plan; or b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not: (a) a non-occupational disease; or (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services:
   a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a dependent age 5 or older if that dependent becomes a covered dependent other than: (a) during the first 31 days the dependent is eligible for this coverage, or (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred: (i) after the end of the 12-month period starting on the date the dependent became a covered dependent; or (ii) as a result of accidental injuries sustained while the dependent was a covered dependent; or (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless: (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with highnoble metals, unless otherwise specified in the Booklet-Certifcate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate. All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide healthcare services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and Indemnity Dental plans are provided or administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Insurance plans are provided by Aetna Life Insurance Company and its affiliates.

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