



Parkway School District Retiree Plan

**Aetna Medicare® Plan (PPO)
with Aetna Medicare Rx® Plan**

Your
next
path

Information packet 2022
Your guide to getting more



151 Farmington Avenue
Hartford, CT 06156

Thank you for your interest in Aetna Medicare

We want you to have a positive health care experience. Our plans can help.

This packet contains:

- Information on the benefits, programs and services available to you
- Details to help you better understand the plan features
- Everything you need to enroll

Ready to get started?

Simply follow these steps:

1. Review the plan benefits in this packet.
2. Fill out and sign the included enrollment form.
3. Make a copy of the form for your records.
4. Mail your completed form to the address shown at the bottom of the Enrollment Instructions page. (You can use the return envelope if one was included.)
5. Follow any other instructions from your employer, union or trust, as applicable.

Questions?

Just call us at **1-800-307-4830 (TTY: 711)**.

We're here 8 AM — 9 PM ET, Monday — Friday.

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A Medicare plan that meets your needs



You deserve a Medicare plan that focuses on your total health and well-being. Let's start with what matters most.

Your confidence



An estimated 39 million people rely on Aetna®, a CVS Health® company, to help them make decisions about their health care and their health care spending.

Your doctors



Our nationwide provider coverage makes it easier to visit the doctors and hospitals you trust most.

Your prescriptions



Our plans cover many of the most commonly prescribed drugs. And you can get most of them delivered right to your door with the CVS Caremark® Mail Service Pharmacy.

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Why Aetna Medicare Advantage

A boost beyond Original Medicare

Our plans cover everything Original Medicare does, along with other things it doesn't. These include:



Additional preventive care benefits



Annual preventive care reminders for important health screenings

Benefits for the whole you

You'll also enjoy other benefits, programs and services to help you get and stay healthier so you can live your best life.

Healthy Home Visit

A licensed health care professional can come to your home to review your health needs and do a home safety assessment. During the visit, they may also review your medications, complete some health screening tests and recommend services that can support your health needs. If you feel more comfortable with a virtual visit, a phone or video option may also be available.



Resources For Living® program

Resources For Living helps you find community support to tackle life's everyday hurdles. It's designed to help you find a wide range of services near you — from personal care, housekeeping and maintenance to caregiver relief, pet care services, and local clubs and social programs.

24-Hour Nurse Line

You can talk to our registered nurses, day or night. They can help you decide if you need a doctor or urgent care center visit, understand your symptoms and learn about treatments.* Of course, in an emergency, dial **911** or go to the closest emergency room.

Nurse care management

These programs can help you manage chronic conditions and understand complex medical issues. If you qualify, we'll assign you a nurse care manager. As your health advocate, they'll work with you and your doctors to support your care plan.

Virtual care

Telehealth: Can't make it into the doctor's office? You can meet virtually with a primary care physician (PCP) or an urgent care center provider by phone, video or mobile app. Check with your PCP or urgent care center to see if they offer telehealth services.

Teladoc®: Teladoc is another virtual care option that gives you access to a national network of U.S. board-certified doctors by phone, video or mobile app. Get quality health care anywhere and anytime.

Whether you choose telehealth or Teladoc, you're covered for many non-emergency medical needs, such as cold and flu symptoms, allergies, skin problems and prescription refills.

*While only your doctor can diagnose, prescribe or give medical advice, our nurses can provide information on more than 5,000 topics. Contact your doctor first with any questions regarding your health care needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.



Aetna® Medicare Advantage with prescription drug coverage

A plan with prescription drug benefits can help cover the cost of your medicine.

You're covered from the doctor's office to the pharmacy

Our all-in-one plan combines medical benefits with prescription drug coverage. So you'll have just one plan and member ID card for your medical and prescription drug needs.



Are your prescription drugs covered?

Our plan covers many of the most commonly prescribed generic and brand-name drugs.

To find your medicine in our formulary (drug list):

- Flip to your plan's Summary of Benefits in the "A closer look" section of this packet
- Write down the formulary name and the plan's tier structure (for example, 3-tier, 5-tier, etc.) shown under "Pharmacy — Prescription Drug Benefits"
- Go to aetnaretireeplans.com.
Scroll down the page
- Choose Formulary – "MAPD"
"2022 GRP B2 MO Formulary – MAPD"

Don't have access to a computer or the internet? Call us at 1-800-307-4830 (TTY: 711).



Pharmacy coverage from coast to coast

Our pharmacy network includes national chains as well as local options for your prescription drugs.



Find a network pharmacy close to you

Visit aetnaretireeplans.com.

Don't have access to a computer or the internet?

Call us at 1-800-307-4830

We're here 8 a.m. to 9 p.m. EST, Monday through Friday.

Save a trip with home delivery



With CVS Caremark® Mail Service Pharmacy, standard shipping is always free. Your medicine is securely packed. Then, it's mailed quickly and safely to you. Registered pharmacists check all orders for accuracy. If you have questions about your medicine, you can call them anytime.



About your plan

Aetna Medicare Plan (PPO)

A PPO is a preferred provider organization plan. It gives you more flexibility when choosing a provider.

You can see any provider, in or out of network. They just have to be licensed, eligible to receive Medicare payments and willing to accept your plan. **But you'll generally pay less for your care when you see a provider in our network.**

With a PPO plan, you'll have the option to choose a primary care physician (PCP). It's not required, but when we know who your doctor is, we can better support your care.

How to look up a provider

- www.aetnaretireeplans.com
- Scroll down the page to "Find a doctor"
- Click on box – "2022 Medicare plans through an employer"
- Enter your zip code
- Click on box "Select plan to find providers"
- Click on PPO
- Click on box – "Aetna Medicare PPO (CVTY)"



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A closer look

Summary of Benefits
Aetna® Medicare Plan (PPO)



PARKWAY SCHOOL DISTRICT
 Aetna MedicareSM Plan (PPO)
 Medicare (S02) PPO Plan
 Custom Rx \$10/\$30/\$50/25%

Benefits and Premiums are effective January 1, 2022 through December 31, 2022

SUMMARY OF BENEFITS
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.	
Annual Deductible	\$0	\$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	Network Services:	Network and out-of-network services:
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	\$1,500	\$11,300 for in and out-of-network services combined
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.		



HOSPITAL CARE*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Inpatient Hospital Care	\$300 per day, days 1-5; \$0 Unlimited Additional Days	25% per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Observation Care	Your cost share for Observation Care is based upon the services you receive.	
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Outpatient Services & Surgery	\$250	25%
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Ambulatory Surgery Center	\$250	25%
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PHYSICIAN SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Primary Care Physician Visits	\$10	25%
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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.

Physician Specialist Visits	\$25	25%
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PREVENTIVE CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Medicare-covered Preventive Services	\$0	25%
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- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.
- Depression screenings



- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings - annually for patients younger than 15 and adults older than 65 at increased risk for HIV infection
- Lung cancer screenings and counseling - Aged 55–77
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams - one routine GYN visit and pap smear every 24 months. All asymptomatic female patients aged 30-65 years.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit
- Bone mass measurements \$0 25%
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) \$0 25%
- For all members aged 50 to 85 years
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes. \$0 25%

Immunizations \$0 \$0

- Flu
- Hepatitis B
- Pneumococcal

Additional Medicare Preventive Services \$0 25%

- Barium enema - one exam every 12 months.
- Diabetes self-management training (DSMT)
- Digital rectal exam (DRE)
- EKG following welcome exam



- Glaucoma screening

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	\$50	\$50
Urgently Needed Care; Worldwide	\$50	\$50
DIAGNOSTIC PROCEDURES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Diagnostic Radiology MRI and CT scans	20%	25%
Lab Services	\$0	25%
Diagnostic testing & procedures	20%	25%
Outpatient X-rays	\$15	25%
HEARING SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Hearing Screening One exam every 12 months.	\$25	25%
Medicare Covered Hearing Examination	\$25	25%
Hearing Aid Reimbursement Applies to in or out of network	\$500 once every 12 months	
DENTAL SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Dental - Value EPO		
Coverage includes cleanings, checkups, X-rays and comprehensive services		
Annual Benefit Maximum - \$750 each year	\$0 dental deductible 0% coinsurance for each preventative dental service	
Medicare Covered Dental* Non-routine care covered by Medicare.	\$25	25%



VISION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	\$25	25%
Diabetic Eye Exams	\$0	25%
Vision Eyewear Reimbursement Applies to in or out of network	\$100 once every 24 months	
MENTAL HEALTH SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$300 per day, days 1-5; \$0 Unlimited Additional Days	25% per stay
Outpatient Mental Health Care Individual visit	\$25	25%
Partial Hospitalization	\$25	25%
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$300 per day, days 1-5; \$0 Unlimited Additional Days	25% per stay
Outpatient Substance Abuse Individual visit	\$25	25%



SKILLED NURSING SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Skilled Nursing Facility (SNF) Care	\$0 per day, days 1-20; \$40 per day, days 21-50; \$0 per day, days 51-100	25% per day, days 1-100

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

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 a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	20%	25%

AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Ambulance Services	\$100	25%

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Transportation (non-emergency)	Not Covered	



MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Medicare Part B Prescription Drugs	20%	25%
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MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Blood	All components of blood are covered beginning with the first pint.	
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Cardiac Rehabilitation Services	20%	25%
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Chiropractic Services*	\$20	25%
Medicare covered benefits only.		

Diabetic Supplies*	\$0	25%
Includes supplies to monitor your blood glucose from LifeScan.		

Durable Medical Equipment/ Prosthetic Devices*	20%	25%
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Home Health Agency Care*	\$0	25%
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Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
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Outpatient Dialysis Treatments*	20%	20%
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Podiatry Services	\$25	25%
Medicare covered benefits only.		

Pulmonary Rehabilitation Services	20%	25%
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Radiation Therapy*	20%	25%
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ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Fitness Benefit	SilverSneakers	
Resources For Living[®]	Covered	
For help locating resources for every day needs.		
Teladoc[™]	\$10	
Telemedicine services with a Teladoc [™] provider. State mandates may apply.		
Telehealth	Covered	
Telemedicine Services. Member cost share will apply based on services rendered.		
Telehealth PCP	\$10	25%
Telehealth Specialist	\$25	25%
Telehealth Other Health care Providers	\$25	25%
Telehealth Individual Mental Health	\$20	25%
Telehealth Group Mental Health	\$20	25%
Telehealth Individual Psychiatric Services	\$20	25%
Telehealth Group Psychiatric Services	\$20	25%
Telehealth Urgent care	\$50	\$50
ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Podiatry	\$25	Not Covered
Routine Physical Exams	\$0	25%
One exam per calendar year		

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

See next page for Pharmacy-Prescription Drug Benefits.



PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-Year deductible for Prescription drugs \$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network S2

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (<http://www.aetnaretireplans.com>.)

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Initial Coverage Limit (ICL) \$4,430

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	Preferred Mail	Standard Retail or Mail
Tier 1 - Generic Generic Drugs	\$10	\$20	\$20
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$30	\$60	\$60
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$50	\$100	\$100



4 Tier Plan	30-day Supply through Retail	90-day Supply through Retail or Mail	
	Standard	Preferred Mail	Standard Retail or Mail
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	25%	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach \$7,050 in prescription drug expenses is indicated below.

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

Catastrophic Coverage:

You pay \$3.95 for a generic drug or a drug that is treated like a generic and \$9.85 for all other drugs.

Catastrophic Coverage benefits start once \$7,050 in true out-of-pocket costs is incurred.

Requirements:

Precertification

Applies

Step-Therapy

Applies



Non-Part D Supplemental Benefit

- Not Covered

Medical Disclaimers

For more information about Aetna plans, go to www.AetnaRetireePlans.com or call Member Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Not all PPO Plans are available in all areas

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other health care 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.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

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.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.



Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Plan Disclaimers

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

Participating physicians, hospitals and other health care 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. Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).



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.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

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 (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711).

Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

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

*****This is the end of this plan benefit summary*****

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Step by step

What happens next

Start your journey off right

You'll hear from us within about 30 days after your enrollment in the plan.



Plan confirmation and acceptance letter

This letter includes information to help you understand your plan's features. We'll send it to you once the Centers for Medicare & Medicaid Services (CMS) approves your enrollment.

You'll get your letter by mail.



Plan member ID card

This card — not your Medicare card — should be used each time you visit the doctor, hospital or pharmacy (if you have prescription drug coverage).

You'll get your member ID card by mail. You can also find it online.



Evidence of Coverage (EOC)

This is a complete description of your Medicare plan coverage and your member rights.

You'll find your EOC online.



Formulary

This is a list of drugs your plan covers and any special requirements (if you have prescription drug coverage).

You'll find your formulary online.



Schedule of Cost Sharing (SOC)

This is the share of costs covered by Aetna that you pay out of your own pocket. This can include deductibles, coinsurance, copayments or similar charges.

You'll get your SOC by mail.



Healthy Home Visit

Expect a call from Aetna® to schedule a Healthy Home Visit. You'll get in-home advice from a licensed health care professional on how to reach your health goals.

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

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

You can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call **1-888-267-2637 (TTY: 711)**, 8 AM to 9 PM ET, Monday through Friday, if you do not receive your mail-order drugs within this time frame. Members may have the option to sign up for automated mail-order delivery.

Aetna Medicare's pharmacy network includes limited lower cost preferred pharmacies in: rural Nebraska, rural Kansas, suburban West Virginia, rural Maine, suburban Arizona, rural Michigan, urban Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call **1-855-338-7027 (TTY: 711)** or consult the online pharmacy directory at **[AetnaMedicare.com/pharmacyhelp](https://www.aetnamedicare.com/pharmacyhelp)**.

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.

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

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 health care 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:

Aetna Medicare is a Medicare Advantage plan and has a contract with the Federal government. 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 (entire) 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.

HMO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services.

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.**

PPO plans: I understand that beginning on the date 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. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

I understand that beginning on the date the Aetna Medicare Advantage plan coverage begins, I must get all of my health care from Aetna Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare 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 health care operations. I also acknowledge that the Aetna Medicare Advantage plan will release my information, including my prescription drug event data 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.



Helpful resources

Keep these helpful resources handy, so you can refer back to them at any time.



Give us a ring

Call us at 1-800-307-4830 (TTY: 711).

We're available 8 a.m. to 9 p.m. EST, Monday through Friday.



Websites to remember

Want more information about the plan and additional wellness programs?
Looking for a doctor or hospital?

Visit aetnaretireeplans.com.
to find all that and more.

Visit **Medicare.gov** for more information about how Medicare works.

HOW TO LOOK UP A PROVIDER

PPO Network Aetna Medicare PPO (CVTY)

How to look up a medical or dental provider

- www.aetnaretireplans.com
- Scroll down the page to “Find a doctor”
- Click on box – “2022 Medicare plans through an employer”
- Enter your zip code
- Click on box “Select plan to find providers”
- Click on HMO
- Click on box – “Aetna Medicare PPO (CVTY)”
- OR
- Click on PPO
- Click on box – “Aetna Medicare PPO (CVTY)”

PPO Network Aetna Medicare PPO (CVTY)

How to look up a prescription:

www.aetnaretireplans.com

Scroll down the page

Choose Formulary – “MAPD”

“2022 GRP B2 MO Formulary – MAPD”



YOUR KEY TO A FULLER, HEALTHIER LIFE

SilverSneakers® is a program designed with you in mind. You have the opportunity to join a group of like-minded people focused on maintaining good health and independence.

BENEFITS OF SILVERSNEAKERS

SilverSneakers is *much more* than an exercise program – it may help you to achieve your *best health in mind, body and spirit.*¹



A no-added-cost fitness benefit with access to thousands of locations nationwide²



SilverSneakers FLEX® classes offered outside the traditional gym setting³



The ability to enroll at multiple locations at any time



Social connections through events such as shared meals, holiday celebrations, and class socials



Online resources (fitness location directory, articles, SilverSneakers On-Demand™ workout videos, and more)



Adjustable workout programs tailored to individual fitness levels, schedule reminders for favorite activities, find convenient locations and more with the SilverSneakers GO™ app



Signature SilverSneakers classes designed for all fitness levels and led by trained instructors³



88%

of participants say SilverSneakers has improved their quality of life.⁴

60%

of participants report that they have made new and valuable friendships through SilverSneakers.⁴

69%

discovered they could do more than they thought possible.⁴

LET'S GET STARTED

Enroll in as many locations as you like and take part in fitness classes, use gym amenities and participate in events in your community.²



**START
HERE**

Go to **SilverSneakers.com/StartHere** to get your SilverSneakers member ID and find fitness locations that are right for you.



**TAKE A
TOUR**

Bring your member ID number with you on your first visit.



**START YOUR
ROUTINE**

You can start slowly, but keep it steady to enjoy a healthier lifestyle.

SilverSneakers.com/StartHere

Questions? Call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET

1. Always talk with your doctor before starting an exercise program.
2. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
3. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.
4. 2018 Annual Participant Survey
SilverSneakers, the SilverSneakers logotype and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2019 Tivity Health, Inc. All rights reserved. AETNA8711MBRFLY0619_T 72.03.765.1



Employer Group Enrollment Form Instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. The instructions for each section of this enrollment form are below. You can use this form to enroll or to submit a plan change if you're already enrolled.

- Effective date:** Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date can't be earlier than the day you sign this form.**
- Former employer information:** Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)
- Personal information:** This is your name, address, phone number, etc. **Please print clearly.**
- Health plan selection:** Check the box next to the plan you want to enroll in. (There may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.
- Select a provider:** **For Aetna Medicare Plan (HMO):** You're required to have a primary care physician (PCP) on file with us. This means you need to tell us who your doctor is. Write in the name of your PCP, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
For Aetna Medicare Plan (PPO): You have the option to choose an Aetna network PCP. But when we know your doctor we can better coordinate your care. Write in the name of your Aetna Network PCP, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
- Medicare information:** This is your Medicare insurance information, found on your red, white and blue Medicare card. Complete all the fields to avoid a delay in your coverage.
- Disclosures:** Read this information carefully.
- Signature required:** Sign and date the application in the space provided.
Authorized representatives: Sign the form and write in your information.
- Make a copy for yourself and return the original:** Make a copy of this entire application for your records. Then return your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may be included for your convenience.

Please call your former employer/union/trust or Aetna Medicare with any questions.

Phone number: 1-800-307-4830 (TTY: 711)
Hours: Monday through Friday, 8 AM to 9 PM ET
Mail to: Aetna Employer Group, PO Box 7082, London, KY 40742
Website: AetnaRetireePlans.com
Fax Number: 1-833-806-0689

Make a copy for yourself and return the original

EG22

Effective date:

/ 01 /

Parkway School District

Group number

Class code

Your information

Last name

First name

Middle initial

Birth date

(__ / __ / ____)
(M M / D D / Y Y Y Y)

Sex

M F

Primary phone number (____) ____ - ____

Secondary phone number (____) ____ - ____

Email address

Permanent residence street address (a PO Box is not allowed)

Apt./Suite/Unit (please specify)

City

County

State

ZIP Code

Mailing address (only if different from your permanent residence street address)

City

State

ZIP Code

Health plan selection

Check the box next to the plan you want to enroll in. Then write the name of the specific plan on the line provided (this information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. **Make sure to read the important health plan disclosures on the last page of this form.**

Aetna Medicare PPO with Rx S02 Custom Rx

Are you enrolled in another Medicare Advantage plan? If yes, fill in the following:

I'm currently enrolled in a Medicare Advantage plan issued by:

Name of insurance company _____

I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Applicant name:

Effective date: / 01 /

Tell us your provider

A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. To select a PCP visit our online provider directory at AetnaMedicare.com/findprovider or call the phone number on the instructions page of this enrollment form.

Write the full name of your PCP

Are you a current patient?

Yes No

Provider ID (if applicable) (located in the provider directory):

Grid for Provider ID

Primary Care ID (located in the provider directory):

Grid for Primary Care ID

Provide your Medicare insurance information

Medicare Number

Is Entitled To: HOSPITAL (Part A) MEDICAL (Part B) Effective Date: / /

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Answer these important questions

- 1. Are you an Aetna member?
2. Are you the retiree?
3. Are you covering a spouse or dependents under this employer, trust or union plan?
4. Was your previous policy terminated?
5. Are you a resident in a long-term care facility, such as a nursing home?
6. Are you enrolled in your state's Medicaid program?
7. Will you have other prescription drug coverage in addition to the Aetna Medicare plan?
8. Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?

Applicant name: _____ **Effective date:** / 01 /

Indicate your preferred spoken language (if not English): Spanish Other _____

Indicate your preferred written language (if not English): Spanish Other _____

If you need information in another language or accessible format (e.g. large print or braille), contact us at **1-888-267-2637 (TTY: 711)** 8 AM to 6 PM, local time, Monday through Friday.

DISCLOSURES – Read this section carefully and sign below

By completing this enrollment application, I agree to the following: Aetna Medicare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare 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 you 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 entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

The Aetna Medicare plan serves a specific service area. If I move out of the area that Aetna Medicare 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'm a member of the Aetna Medicare 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 Aetna when I get it to know which rules I must follow to get coverage with this Medicare 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.

HMO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

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

Release of Information: By joining this Medicare Advantage plan, I acknowledge that the Aetna Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data 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 if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

Signature _____ **Today's date** ____/____/____

If you're the authorized representative helping someone fill out this form, you must sign above and provide the following information.

Representative's name	Address
Phone number (____) _____ - _____	Relationship to enrollee

Employer Group Enrollment Form Instructions

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. The instructions for each section of this enrollment form are below. You can use this form to enroll or to submit a plan change if you're already enrolled.

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- Personal information:** This is your name, address, phone number, etc. **Please print clearly.**
- Health plan selection:** Check the box next to the plan you want to enroll in. (There may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.
- Select a provider:** **For Aetna Medicare Plan (HMO):** You're required to have a primary care physician (PCP) on file with us. This means you need to tell us who your doctor is. Write in the name of your PCP, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
For Aetna Medicare Plan (PPO): You have the option to choose an Aetna network PCP. But when we know your doctor we can better coordinate your care. Write in the name of your Aetna Network PCP, their Provider ID and their Primary Care ID. You'll find this information in your Provider Directory.
- Medicare information:** This is your Medicare insurance information, found on your red, white and blue Medicare card. Complete all the fields to avoid a delay in your coverage.
- Disclosures:** Read this information carefully.
- Signature required:** Sign and date the application in the space provided.
Authorized representatives: Sign the form and write in your information.
- Make a copy for yourself and return the original:** Make a copy of this entire application for your records. Then return your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may be included for your convenience.

Please call your former employer/union/trust or Aetna Medicare with any questions.

Phone number: 1-800-307-4830 (TTY: 711)
Hours: Monday through Friday, 8 AM to 9 PM ET
Mail to: Aetna Employer Group, PO Box 7082, London, KY 40742
Website: AetnaRetireePlans.com
Fax Number: 1-833-806-0689

Make a copy for yourself and return the original

EG22

Effective date:

/ 01 /

Parkway School District

Group number

100022

Class code

Your information

Last name

First name

Middle initial

Birth date

(__ / __ / ____)
(M M / D D / Y Y Y Y)

Sex

M F

Primary phone number (____) ____ - ____

Secondary phone number (____) ____ - ____

Email address

Permanent residence street address (a PO Box is not allowed)

Apt./Suite/Unit (please specify)

City

County

State

ZIP Code

Mailing address (only if different from your permanent residence street address)

City

State

ZIP Code

Health plan selection

Check the box next to the plan you want to enroll in. Then write the name of the specific plan on the line provided (this information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. **Make sure to read the important health plan disclosures on the last page of this form.**

Aetna Medicare PPO with Rx S02 Custom Rx

Are you enrolled in another Medicare Advantage plan? If yes, fill in the following:

I'm currently enrolled in a Medicare Advantage plan issued by:

Name of insurance company _____

I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Applicant name: _____

Effective date: / 01 / _____

Tell us your provider

A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. To select a PCP visit our online provider directory at [AetnaMedicare.com/findprovider](https://www.aetna.com/medicare/find-provider) or call the phone number on the instructions page of this enrollment form.

Write the full name of your PCP _____

Are you a current patient?

Yes No

Provider ID (if applicable) (located in the provider directory): _____

--	--	--	--	--	--	--	--	--	--

Primary Care ID (located in the provider directory): _____

--	--	--	--	--	--	--	--

Provide your Medicare insurance information

Medicare Number _____ - _____ - _____

Is Entitled To:

Effective Date:

HOSPITAL (Part A)

____ / ____ / ____

MEDICAL (Part B)

____ / ____ / ____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Answer these important questions

Yes No

1. **Are you an Aetna member?**

If "Yes," provide your member ID number _____

Yes No

2. **Are you the retiree?** If "Yes," provide retirement date: ____ / ____ / _____

If No, name of retiree: _____

Yes No

3. **Are you covering a spouse or dependents under this employer, trust or union plan?**

If "Yes," name of spouse: _____

Name(s) of dependent(s): _____

Yes No

4. **Was your previous policy terminated?**

If "Yes," provide termination date: ____ / ____ / _____

Yes No

5. **Are you a resident in a long-term care facility, such as a nursing home?**

If "Yes," provide the following information:

Name of facility: _____ Phone number: (____) _____ - _____

Address: _____ State: _____ ZIP: _____

Yes No

6. **Are you enrolled in your state's Medicaid program?**

If "Yes," write in your Medicaid number: _____

Yes No

7. **Will you have other prescription drug coverage in addition to the Aetna Medicare plan?** Some individuals may have other drug coverage, including other private insurance, worker's compensation, TRICARE, Federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

If "Yes," please list your other coverage and identification number(s) for this coverage.

Name of other coverage: _____

ID #: _____ Group #: _____

Yes No

8. **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?** Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.

If "Yes," my coverage started on ____ / ____ / _____ (date) and ended on

____ / ____ / _____ (date).

Name of other coverage: _____

NOTE: If you've not had creditable coverage, you may have to pay a late enrollment penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.

Applicant name: _____ **Effective date:** / 01 /

Indicate your preferred spoken language (if not English): Spanish Other _____

Indicate your preferred written language (if not English): Spanish Other _____

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Representative's name	Address
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