



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	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.

Annual Deductible	\$400
-------------------	-------

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.

Services Exempt from Deductible:
 Annual wellness exams, routine physical exam, routine mammograms, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, additional Medicare preventive care services, emergency room, emergency ambulance services, urgently needed care.

Annual Maximum Out-of-Pocket Amount	\$3,500
-------------------------------------	---------

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.



HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
-----------------------	---

Inpatient Hospital Care	\$250 per day, days 1-5; \$0 Unlimited Additional Days
--------------------------------	--

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.
-------------------------	--

Outpatient Services & Surgery	10%
--	-----

Ambulatory Surgery Center	10%
----------------------------------	-----

PHYSICIAN SERVICES	This is what you pay for network & out-of-network providers.
---------------------------	---

Primary Care Physician Visits	\$10
--------------------------------------	------

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	\$30
------------------------------------	------

PREVENTIVE CARE	This is what you pay for network & out-of-network providers.
------------------------	---

Medicare-covered Preventive Services	\$0
---	-----

- 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
 - Colorectal cancer screenings \$0
(colonoscopy, fecal occult blood test, flexible sigmoidoscopy) - For all members aged 50 to 85 years

 - Medicare Diabetes Prevention \$0
Program - 12 months of core session for program eligible members with an indication of pre-diabetes.

Immunizations \$0

- Flu
- Hepatitis B
- Pneumococcal

Additional Medicare Preventive Services \$0

- 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 & out-of-network providers.
--	--

Emergency Care; Worldwide (waived if admitted)	\$50
--	------

Urgently Needed Care; Worldwide	\$35
--	------

DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
-------------------------------	--

Diagnostic Radiology MRI and CT scans	10%
---	-----

Lab Services	\$20
---------------------	------

Diagnostic testing & procedures	\$20
--	------

Outpatient X-rays	\$20
--------------------------	------

HEARING SERVICES	This is what you pay for network & out-of-network providers.
-------------------------	--

Routine Hearing Screening One exam every 12 months.	\$0
---	-----

Medicare Covered Hearing Examination	\$30
---	------

Hearing Aid Reimbursement Applies to in or out of network	\$500 once every 36 months
---	----------------------------

DENTAL SERVICES	This is what you pay for network & out-of-network providers.
------------------------	--

Medicare Covered Dental* Non-routine care covered by Medicare.	\$30
--	------

VISION SERVICES	This is what you pay for network & out-of-network providers.
------------------------	--

Routine Eye Exams One annual exam every 12 months.	\$30
--	------

Diabetic Eye Exams	\$0
---------------------------	-----



Vision Eyewear Reimbursement \$100 once every 24 months

Applies to in or out of network

MENTAL HEALTH SERVICES* This is what you pay for network & out-of-network providers.

Inpatient Mental Health Care \$250 per day, days 1-5; \$0 Unlimited Additional Days

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

Outpatient Mental Health Care \$30

Individual visit

Inpatient Substance Abuse \$250 per day, days 1-5; \$0 Unlimited Additional Days

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

Outpatient Substance Abuse \$30

Individual visit

SKILLED NURSING SERVICES* This is what you pay for network & out-of-network providers.

Skilled Nursing Facility (SNF) Care \$0 per day, days 1-20; \$75 per day, days 21-100

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 & out-of-network providers.

Outpatient Rehabilitation Services \$30

(Speech, physical, and occupational therapy)



AMBULANCE SERVICES	This is what you pay for network & out-of-network providers.
---------------------------	---

Ambulance Services	\$100
---------------------------	--------------

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 & out-of-network providers.
--------------------------------	---

Transportation (non-emergency)	24 trips with 60 miles allowed per trip
---------------------------------------	--

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network & out-of-network providers.
--	---

Medicare Part B Prescription Drugs	20%
---	------------

MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network & out-of-network providers.
---	---

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 & out-of-network providers.
---	---

Blood	All components of blood are covered beginning with the first pint.
--------------	---

Cardiac Rehabilitation Services	\$20
--	-------------

Chiropractic Services*	\$20
-------------------------------	-------------

Medicare covered benefits only.

Diabetic Supplies*	\$0
---------------------------	------------

Includes supplies to monitor your blood glucose from LifeScan.

Durable Medical Equipment/ Prosthetic Devices*	20%
---	------------

Home Health Agency Care*	\$0
---------------------------------	------------

Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
---------------------	--



CITY OF TAMPA
Aetna MedicareSM Plan PPO
Medicare (P01) ESA PPO
Custom Rx 15\$/25\$/45\$/25%

Outpatient Dialysis Treatments*	\$30
Podiatry Services	\$30
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	\$30
Radiation Therapy*	\$20
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers
Meals	Covered up to 14 meals following an inpatient stay.
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
Telehealth Specialist	\$30
Telehealth Other Health care Providers	\$30
Telehealth Individual Mental Health	\$30
Telehealth Group Mental Health	\$30
Telehealth Individual Psychiatric Services	\$30
Telehealth Group Psychiatric Services	\$30
Telehealth Urgent care	\$35



ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
---	---

Routine Physical Exams	\$0
One exam per calendar year	

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

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	\$15	\$30	\$30



Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$25	\$50	\$50
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$45	\$90	\$90
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: Greater of 5% of the cost of the drug - or - \$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

Enhanced Drug Benefit

- Agents used for cosmetic purposes or hair growth
 - Agents used to promote fertility
 - Agents when used for anorexia, weight loss, or weight gain
 - Agents when used for the symptomatic relief of cough and colds
 - Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

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.

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.



CITY OF TAMPA
Aetna MedicareSM Plan PPO
Medicare (P01) ESA PPO
Custom Rx 15\$/25\$/45\$/25%

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
 - 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



CITY OF TAMPA
Aetna MedicareSM Plan PPO
Medicare (P01) ESA PPO
Custom Rx 15\$/25\$/45\$/25%

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

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

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the "Enhanced Drug Benefit" section in the chart above. Non-Part D drugs covered under the enhanced drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

Plan Disclaimers



CITY OF TAMPA
Aetna MedicareSM Plan PPO
Medicare (P01) ESA PPO
Custom Rx 15\$/25\$/45\$/25%

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*****

©2021 Aetna Inc.

Y0001_GRP_1099_3732a_2021_M