Aetna Life Insurance Company

Former Employer/Union/Trust Name: THE CITY OF SEATTLE
Group Agreement Effective Date: 01/01/2019
Group Number: 430517

This *Prescription Drug Schedule of Cost Sharing* is part of the *Evidence of Coverage* (EOC) for our plan. When the EOC refers to the attachment for details of Medicare Part D prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart. (See the EOC chapters titled "Using the plan's coverage for your Part D prescription drugs" and "What you pay for your Part D prescription drugs.")

Annual Deductible Amount per Member	$0
Formulary Type:	GRP B2
Number of Cost Share Tiers:	5 Tier
Initial Coverage Limit:	$3,820
True Out-of-Pocket Amount:	$5,100

Retail Pharmacy Network: S2

The name of your pharmacy network is listed above. To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (http://www.aetnamedicare.com/findpharmacy), or call Customer Service (phone numbers are printed on the back of your member ID card).

Every drug on the plan's Drug List is in one of the cost-sharing tiers described below:

- Tier One – Preferred generic drugs: Includes low-cost generic drugs
- Tier Two – Generic drugs: Includes generic drugs
- Tier Three – Preferred brand drugs: Includes preferred brand drugs and some high-cost generic drugs
- Tier Four – Non-preferred drugs: Includes non-preferred brand drugs and some higher-cost generic drugs
- Tier Five – Specialty drugs: Includes high-cost/unique brand and generic drugs

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List. If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Initial Coverage Stage: Amount you pay, up to $3,820 in total covered prescription drug expenses.

Initial Coverage	**One-Month Supply**			**Extended Supply**	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	$5	$5	$5	$12.50	$12.50
Tier 2 Generic drugs - Includes generic drugs	$20	$20	$20	$50	$50

Initial Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	$40	$40	$40	$100	$100
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	$65	$65	$65	$162.50	$162.50
Tier 5 Specialty drugs - Includes high-cost/unique brand and generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug	Limited to one-month supply	Limited to one-month supply

*Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Coverage Gap Stage: Amount you pay after you reach $3,820 in total covered prescription drug expenses and until you reach $5,100 in out-of-pocket covered prescription drug costs.

Your plan's gap coverage is listed in the chart below.

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	$5	$5	$5	$12.50	$12.50
Tier 2 Generic drugs - Includes generic drugs	$20	$20	$20	$50	$50
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs

Supplemental Gap Coverage	One-Month Supply			Extended Supply	
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing*** (up to a 30-day supply)	**Standard retail or standard mail order cost-sharing** (up to a 90-day supply)	**Preferred mail order cost-sharing** (up to a 90-day supply)
Tier 5 Specialty drugs - Includes high-cost/unique brand and generic drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	37% for generic drugs and 25% for brand drugs	Limited to one-month supply	Limited to one-month supply

*****Out-of-network coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled "Using the plan's coverage for your Part D prescription drugs," Section 2.5.

Your former employer/union/trust provides some additional coverage during the Coverage Gap stage for covered drugs. Your cost share appears in the chart above.

For brand drugs not included in the additional coverage provided by your former employer/union/trust, the Medicare Coverage Gap Discount Program applies. The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both 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.

You also receive some coverage for generic drugs. You pay no more than 37% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 37% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is $5,100. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching $5,100 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount: –*either* – coinsurance of 5% of the cost of the drug –*or*– $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs. Our plan pays the rest of the cost.

Step Therapy

Your plan includes step therapy. This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

This Plan Uses the GRP B2 Formulary:

Your plan uses the GRP B2 formulary, which means that only drugs on Aetna's drug list will be covered under your plan as long as the drug is medically necessary and the plan rules are followed. Tiers labeled as brand, preferred brand, and non-preferred drug will also include some high-cost generic drugs. Non-preferred copayment levels may apply to some drugs on the drug list. If it is medically necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit, but is not on our formulary, you can contact Aetna to request a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2019 Group Formulary (List of Covered Drugs)* for more information.

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Important reminder– provider directory

Our provider networks have changed. It is important to know if your provider(s) are in the network.

2019 Provider directories are available on **September 30, 2018**.

If you need help finding a provider, or if you'd like us to mail a directory to you, please call the number on your ID card for assistance.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. 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. The pharmacy or provider network may change at any time. You will receive notice when necessary.

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