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MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name: IAMAW Local 1976-US Airways
Policy Period Start Date: 01/01/2023
Policy Period End Date: 12/31/2023
Medical Plan: Medicare (P02) PPO
Pharmacy Plan: Rx 1604

- Please refer to the Financial Conditions and Plan Design Exhibits for an outline of the level of benefits quoted, as well as the terms and conditions of this proposal.
- Your Aetna Group Medicare Plan for January 1, 2023 will be automatically renewed if we do not hear from you by October 1, 2022.
- Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year and are subject to CMS contract approval.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates exclude commissions.
- The proposed Pharmacy rates include a reduction of \$4.46 for the conversion to the Aetna P1 Preferred Pharmacy Network.

	Medical Rate	Pharmacy Rate	Total Rate
Current	\$118.16	\$170.59	\$288.75
Proposed	\$119.34	\$176.37	\$295.71
Change	\$1.18	\$5.78	\$6.96

Total Medicare Eligible Members	18
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State	Medicare Eligible Members	Medical Rate	Pharmacy Rate	Total Rate
Ohio	2	\$119.34	\$176.37	\$295.71
Pennsylvania	16	\$119.34	\$176.37	\$295.71



IAMAW LOCAL 1976-US AIRWAYS

Aetna MedicareSM Plan (PPO)

Medicare (P02) PPO

Rx 1604

Benefits and Premiums are effective January 1, 2023 through December 31, 2023

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 provider 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	\$5,100 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	\$0 per stay	20% per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Observation Stay	Your cost share for Observation Care is based upon the services you receive	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay	per stay

Outpatient Services & Surgery	\$0	20%
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Ambulatory Surgery Center	\$0	20%
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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	20%
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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	\$20	20%
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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	20%
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- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- 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.



- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screenings
- Diabetes screenings
- HBV infection screening
- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams - one routine GYN visit and pap smear every 24 months.
- 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

Immunizations	\$0	\$0
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- Flu
- Hepatitis B
- Pneumococcal

Additional Medicare Preventive Services	\$0	20%
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- 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	\$35	\$35
DIAGNOSTIC PROCEDURES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Diagnostic Radiology CT scans	\$20	20%
Diagnostic Radiology Other than CT scans	\$20	20%
Lab Services	\$0	20%
Diagnostic testing & procedures	\$20	20%
Outpatient X-rays	\$0	20%
HEARING SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Hearing Screening We cover one every twelve months	\$0	20%
Medicare Covered Hearing Examination	\$20	20%
Hearing Aid Reimbursement Applies to in or out of network	\$1,000 once every 36 months	
Hearing Aid Benefit Vendor:	N/A Not Covered	
DENTAL SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Covered Dental* Non-routine care covered by Medicare.	\$20	20%



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.	\$0	20%
Diabetic Eye Exams	\$0	20%
Medicare Covered Eye Exam	\$20	20%
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.	\$0 per stay	20% per stay
Outpatient Mental Health Care Individual visit	\$20	20%
Partial Hospitalization	\$20	20%
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	\$0 per stay	20% per stay
Outpatient Substance Abuse Individual visit	\$20	20%
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 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.	\$0 per day, days 1-100	20% per day, days 1-100



PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	\$20	20%
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AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
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Ambulance Services	\$0	\$100
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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.
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Transportation (non-emergency)	Not Covered	
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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	\$0	20%
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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.
Allergy Shots	\$0	20%
Allergy Testing	\$20	20%
Blood	\$0	20%
All components of blood are covered beginning with the first pint.		
Cardiac Rehabilitation Services	\$20	20%
Chiropractic Services*	\$15	20%
Medicare covered benefits only.		
Diabetic Supplies*	0%	\$0
Includes supplies to monitor your blood glucose from LifeScan.		
Durable Medical Equipment/ Prosthetic Devices*	\$0	20%
Home Health Agency Care*	\$0	20%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	\$20	20%
Outpatient Dialysis Treatments*	\$20	\$20
Podiatry Services	\$20	20%
Medicare covered benefits only.		
Pulmonary Rehabilitation Services	\$20	20%
Radiation Therapy*	\$20	20%



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[™]	\$0	
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	20%
Telehealth Specialist	\$20	20%
Telehealth Other Health care Providers	\$20	20%
Telehealth Individual Mental Health	\$20	20%
Telehealth Behavioral Health	\$0	
Vendor: MD Live		
Telehealth Group Mental Health	\$20	20%
Telehealth Individual Psychiatric Services	\$20	20%
Telehealth Group Psychiatric Services	\$20	20%
Telehealth Urgent care	\$35	\$35
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 Physical Exams	\$0	20%
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 P1

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

Formulary (Drug List) Classic

Initial Coverage Limit (ICL) \$4,660

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		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
Tier 1 - Generic Generic Drugs	\$9	\$10	\$18	\$18	\$20
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$20	\$20	\$40	\$40	\$40
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$50	\$50	\$100	\$100	\$100
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	\$50	\$50	Limited to one-month supply	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 \$7,400 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:

Your share of the cost for a covered drug will be 5% but not greater than the cost share amounts listed in the Initial Coverage Stage section above.

Catastrophic Coverage benefits start once \$7,400 in true out-of-pocket costs is incurred.

Requirements:

Precertification

Applies

Step-Therapy

Applies

Non-Part D Supplemental Benefit

- Agents when used for the treatment of sexual or erectile dysfunction (ED)

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).

Aetna's pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban Utah, Suburban West Virginia, Suburban Wyoming. 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, please call 1-866-241-0357 (TTY: 711) or consult the online pharmacy directory at <http://www.aetnaretireeplans.com>.

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.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

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

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the non-part D supplemental 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

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

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). 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.

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

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

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 2023 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.aetnaretireeplans.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).



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

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