

2017 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**AETNA LIFE INSURANCE COMPANY****Former Employer/Union/Trust Name: Kansas State Employee Health Plan****Group Agreement Effective Date: January 1, 2017****Group Number: AE466595, AE466596, AE466597, AE466598**

This Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) 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
Initial Coverage Limit:	\$3,700
True Out-of-Pocket Amount:	\$4,950
Retail Pharmacy Network: S2	
The name of your pharmacy network is listed above. To find a network pharmacy, you can look in your <i>Pharmacy Directory</i> , visit our website (http://www.aetnamedicare.com/findpharmacy), or call Customer Service (phone numbers are printed on the back of your member ID card).	

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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 \$3,700 in total covered prescription drug expenses.

Five Tier Plan	Standard retail cost-sharing (in-network) (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)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)
Tier 1 Preferred generic drugs - Includes low-cost generic drugs	25% with \$30 max	25% with \$45 max	25% with \$45 max	25% with \$30 max	25% with \$30 max
Tier 2 Generic drugs - Includes generic drugs	25% with \$30 max	25% with \$45 max	25% with \$45 max	25% with \$30 max	25% with \$30 max
Tier 3 Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	25% with \$100 max	25% with \$150 max	25% with \$150 max	25% with \$100 max	25% with \$100 max
Tier 4 Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	50% with \$150 max	50% with \$225 max	50% with \$225 max	50% with \$150 max	50% with \$150 max
Tier 5 Specialty drugs - Includes high-cost/unique brand and generic drugs	25%	Not Available	Not Available	25%	25%

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*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 \$3,700 in total covered prescription drug expenses and until you reach \$4,950 in out-of-pocket covered prescription drug costs.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This supplemental gap coverage is listed in the below chart.

Supplemental Gap Coverage Tiers	Standard retail cost-sharing (in-network) (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)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing* (up to a 30-day supply)
Tier 1 Preferred generic drugs – Includes low-cost generic drugs	25% with \$30 max	25% with \$45 max	25% with \$45 max	25% with \$30 max	25% with \$30 max
Tier 2 Generic drugs – Includes generic drugs	25% with \$30 max	25% with \$45 max	25% with \$45 max	25% with \$30 max	25% with \$30 max
Tier 3 Preferred brand drugs – Includes preferred brand drugs and some high-cost generic drugs	25% with \$100 max	25% with \$150 max	25% with \$150 max	25% with \$100 max	25% with \$100 max
Tier 4 Non-preferred drugs – Includes non-preferred brand drugs and some higher-cost generic drugs	40% with \$150 max	40% with \$225 max	40% with \$225 max	40% with \$150 max	40% with \$150 max
Tier 5 Specialty drugs – Includes high-cost/unique brand and generic drugs	25%	Not Available	Not Available	25%	25%

*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 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

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application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching \$4,950 in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	<p>Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:</p> <p>–<i>either</i> – coinsurance of 5% of the cost of the drug</p> <p>–<i>or</i> – \$3.30 copayment for a generic drug or a drug that is treated like a generic. Or a \$8.25 copayment for all other drugs.</p>
	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 a GRP B2 Formulary:

Your plan uses a 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 2017 Group Formulary (List of Covered Drugs)* for more information.