

**AETNA LIFE INSURANCE COMPANY**

**Former Employer/Union/Trust Name: Kansas State Employee Health Plan**  
**Group Agreement Effective Date: January 1, 2017**  
**Group Number:**

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.”)

<b>Annual Deductible Amount per Member</b>	<b>\$100</b>
<b>Formulary Type:</b>	<b>GRP A1</b>
<b>Initial Coverage Limit:</b>	<b>\$3,700</b>
<b>True Out-of-Pocket Amount:</b>	<b>\$4,950</b>
<b>Retail Pharmacy Network: P1</b> The name of your pharmacy network is listed above. Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing. To find a network pharmacy, you can look in your <i>Pharmacy Directory</i> , visit our website ( <a href="http://www.aetnamedicare.com/findpharmacy">http://www.aetnamedicare.com/findpharmacy</a> ), or call Customer Service (phone numbers are printed on the back of your member ID card).	

**2017 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

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.

**Standard Cost Share:** Chart below lists amount you pay at a pharmacy that offers standard cost sharing:

<b>Five Tier Plan</b>	<b>Standard retail cost-sharing (in-network)</b> (up to a 30-day supply)	<b>Standard retail or standard mail order cost-sharing</b> (up to a 90-day supply)	<b>Preferred mail order cost-sharing</b> (up to a 90-day supply)	<b>Long-term care (LTC) cost-sharing</b> (up to a 31-day supply)	<b>Out-of-network cost-sharing*</b> (up to a 30-day supply)
<b>Tier 1</b> Preferred generic drugs - Includes low-cost generic drugs	\$19	\$38	\$16	\$19	\$19
<b>Tier 2</b> Generic drugs - Includes generic drugs	\$20	\$40	\$30	\$20	\$20
<b>Tier 3</b> Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	\$47	\$94	\$80	\$47	\$47
<b>Tier 4</b> Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	\$100	\$200	\$160	\$100	\$100
<b>Tier 5</b> 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.

**2017 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

**Preferred Cost Share:** Chart below lists amount you pay at a pharmacy that offers preferred cost sharing:

<b>Five Tier Plan</b>	<b>Standard retail cost-sharing (in-network) (up to a 30-day supply)</b>	<b>Standard retail or standard mail order cost-sharing (up to a 90-day supply)</b>	<b>Preferred mail order cost-sharing (up to a 90-day supply)</b>	<b>Long-term care (LTC) cost-sharing (up to a 31-day supply)</b>	<b>Out-of-network cost-sharing* (up to a 30-day supply)</b>
<b>Tier 1</b> Preferred generic drugs - Includes low-cost generic drugs	\$8	\$16	\$16	\$8	\$8
<b>Tier 2</b> Generic drugs - Includes generic drugs	\$15	\$30	\$30	\$15	\$15
<b>Tier 3</b> Preferred brand drugs - Includes preferred brand drugs and some high-cost generic drugs	\$40	\$80	\$80	\$40	\$40
<b>Tier 4</b> Non-preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	\$80	\$160	\$160	\$80	\$80
<b>Tier 5</b> 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.

**2017 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

**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.

**Standard Cost Share:** Chart below lists amount you pay, during the coverage gap, at a pharmacy that offers standard cost sharing:

<b>Supplemental Gap Coverage Tiers</b>	<b>Standard retail cost-sharing (in-network) (up to a 30-day supply)</b>	<b>Standard retail or standard mail order cost-sharing (up to a 90-day supply)</b>	<b>Preferred mail order cost-sharing (up to a 90-day supply)</b>	<b>Long-term care (LTC) cost-sharing (up to a 31-day supply)</b>	<b>Out-of-network cost-sharing* (up to a 30-day supply)</b>
<b>Tier 1</b> Preferred generic drugs	\$19	\$38	\$16	\$19	\$19
<b>Tier 2</b> Generic drugs	\$20	\$40	\$30	\$20	\$20

\*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.

For drug coverage on any tiers not listed in the above chart, the Medicare Coverage Gap Discount Program applies. The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 40% 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 51% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (49%) 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 51% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2017, that amount is \$4,950. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

\*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.

**2017 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

**Preferred Cost Share:** Chart below lists amount you pay, during the coverage gap, at a pharmacy that offers preferred cost sharing:

<b>Supplemental Gap Coverage Tiers</b>	<b>Standard retail cost-sharing (in-network) (up to a 30-day supply)</b>	<b>Standard retail or standard mail order cost-sharing (up to a 90-day supply)</b>	<b>Preferred mail order cost-sharing (up to a 90-day supply)</b>	<b>Long-term care (LTC) cost-sharing (up to a 31-day supply)</b>	<b>Out-of-network cost-sharing* (up to a 30-day supply)</b>
<b>Tier 1</b> Preferred generic drugs	\$8	\$16	\$16	\$19	\$19
<b>Tier 2</b> Generic drugs	\$15	\$30	\$30	\$20	\$20

\*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.

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You also receive some coverage for generic drugs. You pay no more than 51% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (49%) 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 51% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2017, that amount is \$4,950. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

\*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.

**2017 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

**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> <p style="text-align: center;">Our plan pays the rest of the cost.</p>

**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 A1 Formulary:**

Your plan uses a GRP A1 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.