# Aetna Life Insurance Company

**Former Employer/Union/Trust Name: OCCIDENTAL PETROLEUM**
**Group Agreement Effective Date: 01/01/2020**
**Group Number: 467282, 467283**

This Prescription Drug Benefits Chart (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** | **$0** |
| **Formulary Type:** | Open 2 Plus |
| **Number of Cost Share Tiers:** | 4 Tier |
| **Initial Coverage Limit:** | $4,020 |
| **True Out-of-Pocket Amount:** | $6,350 |

**Retail Pharmacy Network:** P1

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. The Aetna Medicare pharmacy network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost-sharing may be less at pharmacies with preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs.

The pharmacy network includes limited lower-cost, preferred pharmacies in **rural areas of Maine, Michigan, and Nebraska, suburban areas of Illinois and South Carolina, and urban areas of Michigan.** The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. To find a network pharmacy, or find up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Customer Service at the number on the back of your member ID card or consult the online *Pharmacy Directory* at aetnamedicare.com/findpharmacy.

| **Maximum Out-of-Pocket Amount** | $1,500 |
|---|---|
| Once your individual out-of-pocket expenses reach this amount, you will pay $0 for all covered prescription drugs for the remainder of the plan year. | |

**Enhanced Drug Benefit**

We offer additional coverage for some prescription drugs not normally covered in a Medicare prescription drug plan, including the following:

- Drugs when used for the relief of cough or cold symptoms
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for weight loss
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Drugs when used for the treatment of erectile dysfunction

The cost share for these drugs is listed in the table below. See Tier 1 for the generic cost share amount and Tier 2 for the brand cost share amount. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. Limitations, such as quantity limits and prior authorization requirements, can be found in the formulary included in this mailing. In addition, if you are receiving "Extra Help" from Medicare to pay for your prescriptions, the "Extra Help" will not pay for these drugs. Please refer to your formulary or call Customer Service for more information.

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

- Tier One – Generic drugs
- Tier Two – Preferred brand drugs
- Tier Three – Non-preferred brand drugs
- Tier Four – 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 $4,020 in total covered prescription drug expenses.

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

| **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 cost-sharing** (up to a 90-day supply) | **Preferred mail order cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic | $10 | $10 | $10 | $30 | $20 |
| **Tier 2** Preferred brand | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $30, whichever is greater, but not more than $150 for your drug | You pay a minimum of 25% or $20, whichever is greater, but not more than $100 for your drug |
| **Tier 3** Non-preferred brand | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |
| **Tier 4** Specialty | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |

*****Out-of-network **c**overage 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.

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

| **Initial Coverage** | **One-Month Supply** | | | **Extended Supply** | |
|---|---|---|---|---|---|
| | **Preferred 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) | **Preferred retail cost-sharing** (up to a 90 day supply) | **Preferred mail order cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic | $9 | $9 | $9 | $27 | $20 |
| **Tier 2** Preferred brand | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $30, whichever is greater, but not more than $150 for your drug | You pay a minimum of 25% or $20, whichever is greater, but not more than $100 for your drug |
| **Tier 3** Non-preferred brand | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |
| **Tier 4** Specialty | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |

**Coverage Gap Stage:** Amount you pay after you reach $4,020 in total covered prescription drug expenses and until you reach $6,350 in out-of-pocket covered prescription drug costs.

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

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

| **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 or CVS Retail cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic | $10 | $10 | $10 | $30 | $20 |
| **Tier 2** Preferred brand | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $30, whichever is greater, but not more than $150 for your drug | You pay a minimum of 25% or $20, whichever is greater, but not more than $100 for your drug |
| **Tier 3** Non-preferred brand | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |
| **Tier 4** Specialty | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |

*****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.

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

| **Supplemental Gap Coverage** | **One-Month Supply** | | | **Extended Supply** | |
|---|---|---|---|---|---|
| | **Preferred 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) | **Preferred retail cost-sharing** (up to a 90-day supply) | **Preferred mail order cost-sharing** (up to a 90-day supply) |
| **Tier 1** Generic | $9 | $9 | $9 | $27 | $20 |
| **Tier 2** Preferred brand | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $10, whichever is greater, but not more than $50 for your drug | You pay a minimum of 25% or $30, whichever is greater, but not more than $150 for your drug | You pay a minimum of 25% or $20, whichever is greater, but not more than $100 for your drug |
| **Tier 3** Non-preferred brand | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |

| | | | | | |
|---|---|---|---|---|---|
| **Tier 4**<br>Specialty | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $25, whichever is greater, but not more than $100 for your drug | You pay a minimum of 25% or $75, whichever is greater, but not more than $300 for your drug | You pay a minimum of 25% or $50, whichever is greater, but not more than $200 for your drug |

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 state 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 Stage:** Amount you pay for covered prescription drugs after reaching $6,350 in out-of-pocket prescription drug costs.

| Prescription Drug Quantity | All covered prescription drugs |
|---|---|
| Per prescription or refill | You pay $0<br>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 Open 2 Plus Formulary:**

Your plan uses the Open 2 Plus formulary, which means you have coverage for every drug identified by Medicare as a part D drug, as long as the drug is medically necessary and the plan rules are followed. Non-preferred copay levels apply to some drugs on the drug list. Review the *Aetna Medicare 2020 Group Formulary (List of Covered Drugs)* for more information.