# Summary of Benefits 2021

## Aetna Medicare Choice Plan (PPO)
## H5521 - 206
## January 1, 2021 - December 31, 2021

H5521-206

Aetna Medicare Choice Plan (PPO) is a PPO plan. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care.

**Service area: California:** Fresno

H5521.206.1_A

**Compare our plan to Medicare**

To learn more about the coverage and costs of Original Medicare, look in your "Medicare & You" handbook. View it online at www.medicare.gov or get a copy 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.

**What you should know**

- **Primary Care Physician (PCP):** You have the option to choose a PCP. When we know who your doctor is, we can better support your care.
- **Referrals:** Aetna Medicare Choice Plan (PPO) 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.

You can find more details on each benefit listed below in the Evidence of Coverage (EOC).

| Plan costs & information | In-network | Out-of-network |
|---|---|---|
| Monthly plan premium | $89 | |
| | You must continue to pay your Medicare Part B premium. | |
| Plan deductible | $0 | $750 |
| | This is the amount you pay for certain services before Aetna Medicare Choice Plan (PPO) begins to pay. The plan deductible applies only to certain out-of-network services. | |
| Maximum out-of-pocket amount (does not include prescription drugs) | $7,550 for in-network services. | $11,300 for in and out-of-network services combined. |
| | The most you pay for copays, coinsurance, and other costs for medical services for the year. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drugs don't count toward the maximum out-of-pocket. | |

| Primary benefits | Your costs for in-network care | Your costs for out-of-network care |
|---|---|---|
| **Hospital coverage*** | | |
| Inpatient hospital coverage | $395 per day, days 1-5; $0 per day, days 6-90<br><br>You pay $0 for days 91 and beyond. | 40% per stay after your plan deductible |
| | Our plan covers an unlimited number of days. | |
| Outpatient hospital observation services | $350 | 40% after your plan deductible |
| Outpatient hospital services | $40 - $350 | 40% after your plan deductible |
| | Lower cost sharing applies for services other than surgery. | |
| Ambulatory surgical center | $350 | 40% after your plan deductible |
| **Doctor visits** | | |
| Primary care physician (PCP) | $5 | 40% after your plan deductible |
| Specialists | $40 | 40% after your plan deductible |

<table>
<tr><th>Primary benefits</th><th>Your costs for in-network care</th><th>Your costs for out-of-network care</th></tr>
<tr><td rowspan="3">Preventive care</td><td colspan="2">$0</td><td>0% - 40%</td></tr>
<tr><td>Preventive care includes:<ul><li>Abdominal aortic aneurysm screenings</li><li>Alcohol misuse screenings & counseling</li><li>Bone mass measurements</li><li>Breast cancer screening: mammogram</li><li>Cardiovascular disease screenings</li><li>Cardiovascular behavior therapy</li><li>Cervical & vaginal cancer screenings</li></ul></td><td><ul><li>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li><li>Depression screenings</li><li>Diabetes screenings</li><li>HBV infection screening</li><li>Hepatitis C screening tests</li><li>HIV screenings</li><li>Lung cancer screenings</li><li>Nutrition therapy services</li></ul></td><td><ul><li>Obesity behavior therapy</li><li>Prostate cancer screenings (PSA)</li><li>Sexually transmitted infections screenings & counseling</li><li>Tobacco use cessation counseling</li><li>Vaccines: flu, hepatitis B, pneumococcal</li><li>Welcome to Medicare preventive visit</li><li>Yearly wellness visit</li></ul></td></tr>
<tr><td colspan="3">Lower cost sharing out-of-network: for pneumonia, influenza, and Hepatitis B vaccines<br>Higher cost sharing out-of-network: for all other Medicare-covered preventive services</td></tr>
<tr><td colspan="4">Emergency & urgent care</td></tr>
<tr><td>Emergency care in the United States</td><td colspan="3">$90</td></tr>
<tr><td>Urgently needed care in the United States</td><td colspan="3">$40</td></tr>
<tr><td>Emergency & urgently needed care worldwide</td><td colspan="3">Emergency care: $90<br>Urgently needed care: $90<br>Ambulance: $285</td></tr>
<tr><td colspan="4">Diagnostic testing*</td></tr>
<tr><td>Diagnostic radiology (e.g. MRI & CT scans)</td><td colspan="2">$295</td><td>40% after your plan deductible</td></tr>
</table>

| Primary benefits | Your costs for in-network care | Your costs for out-of-network care |
|---|---|---|
| Lab services | $0 - $35 | 40% after your plan deductible |
| | Lower cost sharing: for Hemoglobin A1c, Prothrombin (Protime), and urine Albumin<br>Higher cost sharing: for all other covered lab services | |
| Diagnostic tests & procedures | $40 | 40% after your plan deductible |
| Outpatient x-rays | $40 | 40% after your plan deductible |
| **Hearing, dental, & vision** | | |
| For benefits that offer a reimbursement, you can see any licensed provider who is eligible under Medicare. | | |
| Diagnostic hearing exam | $40 | 40% after your plan deductible |
| Routine hearing exam | $0 | 40% after your plan deductible |
| | We cover one exam every year. All appointments should be scheduled through NationsHearing. | |
| Hearing aids | Our plan pays up to a maximum amount of $1,250 per ear, every year. You are responsible for any costs over this amount. | |
| | NationsHearing will manage your hearing aid benefits. All hearing aids must be purchased through NationsHearing. | |
| Dental services | $500 reimbursement every year for covered services. Teeth whitening is not covered. | |
| Glaucoma screening | $0 | 40% after your plan deductible |
| Diagnostic eye exams (including diabetic eye exams) | $0 - $40 | 40% after your plan deductible |
| | Lower cost sharing: for first diabetic eye exam<br>Higher cost sharing: for all other eye exams | |
| Routine eye exam | $0 | 40% after your plan deductible |
| | We cover one exam every year. | |
| Contacts and eyeglasses | $150 reimbursement every year. | |

| Primary benefits | Your costs for in-network care | Your costs for out-of-network care |
|---|---|---|
| **Mental health services*** | | |
| Inpatient psychiatric stay | $1,871 per stay | 40% per stay after your plan deductible |
| Outpatient mental health therapy (individual) | $40 | 40% after your plan deductible |
| Outpatient psychiatric therapy (individual) | $40 | 40% after your plan deductible |
| **Skilled nursing*** | | |
| Skilled nursing facility (SNF) | $0 per day, days 1-20; $184 per day, days 21-100 | 40% per stay after your plan deductible |
| | Our plan covers up to 100 days per benefit period. | |
| **Therapy*** | | |
| Physical and speech therapy | $40 | 40% after your plan deductible |
| **Ambulance & routine transportation** | | |
| Ground ambulance (one-way trip) | $285 | $285 after your plan deductible |
| Air ambulance* (one-way trip) | $285 | $285 after your plan deductible |
| Routine transportation (non-emergency) | Not Covered | Not Covered |
| **Medicare Part B drugs*** | | |
| Chemotherapy drugs | 20% | 40% after your plan deductible |
| Other Part B drugs | 20% | 40% after your plan deductible |

***** Prior authorization may be required for these benefits. See the EOC for details.

| **Prescription drugs** (Your costs may be lower if you qualify for Extra Help) | | | | |
|---|---|---|---|---|
| **Formulary name** | B2 (You can use this when referencing our list of covered drugs) | | | |
| **Stage 1: Deductible**<br>You pay the full cost of drugs until you reach your deductible. | | | | |
| This plan doesn't have a deductible, so your coverage begins at Stage 2. | $0 | | | |
| **Stage 2: Initial coverage**<br>You pay the costs below until your total drug costs reach $4,130. You pay the copay listed below or the cost of the drug, whichever is lower. These cost shares may also apply to Home Infusion drugs when obtained through your Part D benefit. For Long Term Care, you'll get a 31 day supply and pay the Standard cost-share. | | | | |
| | **30-day supply through Retail or Mail** | | **90-day supply through Retail or Mail** | |
| | **Preferred** | **Standard** | **Preferred** | **Standard** |
| Tier 1: Preferred Generic | $0 | $15 | $0 | $45 |
| Tier 2: Generic | $10 | $20 | $25 | $60 |
| Tier 3: Preferred Brand | $47 | $47 | $141 | $141 |
| Tier 4: Non-Preferred Drug | $100 | $100 | $300 | $300 |
| Tier 5: Specialty | 33% | 33% | N/A | N/A |
| **Stage 3: Coverage gap**<br>Our plan offers some coverage in this stage. The coverage gap lasts until your out-of-pocket drug costs reach $6,550. | | | | |
| | **30-day supply** | | | |
| | **Preferred** | **Standard** | | |
| Tier 1: Preferred Generic | $0 | $15 | | |
| Tier 2: Generic | $10 | $20 | | |
| All other Brand Name Drugs | 25% of the plan's cost | | | |
| All other Generic Drugs | 25% of the plan's cost | | | |

| **Prescription drugs** (Your costs may be lower if you qualify for Extra Help) | |
|---|---|
| **Stage 4: Catastrophic coverage**<br>You pay a small cost share for each drug. | |
| Generic Drugs | You pay the greater of 5% of the cost of the drug or $3.70 |
| Brand Name Drugs | You pay the greater of 5% of the cost of the drug or $9.20 |

| **Other benefits** | **Your costs for in-network care** | **Your costs for out-of-network care** |
|---|---|---|
| **Equipment, prosthetics, & supplies*** | | |
| Diabetic supplies | 0% - 20% | 0% - 20% after your plan deductible |
| | We only cover OneTouch/Lifescan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices for 0%.<br><br>We will only cover other brands with a medical exception. If we approve an exception, non-OneTouch/Lifescan supplies are covered at 20%. | |
| Durable medical equipment (e.g. wheelchair, oxygen) | 20% | 40% after your plan deductible |
| Prosthetics (e.g. braces, artificial limbs) | 20% | 40% after your plan deductible |
| **Substance abuse*** | | |
| Outpatient substance abuse (Individual therapy) | $40 | 40% after your plan deductible |

* Prior authorization may be required for these benefits. See the EOC for details.

| **Additional benefits and services provided by Aetna Medicare Choice Plan (PPO)** | **Benefit information** |
|---|---|
| Fitness | Standard membership at participating SilverSneakers® facilities and access to online wellness related tools, planners, newsletters, and classes, at no extra cost.<br><br>You can get an at-home fitness kit if you don't live near a participating club or prefer to exercise at home. |

| Additional benefits and services provided by Aetna Medicare Choice Plan (PPO) | Benefit information |
|---|---|
| Help during a COVID-19 Public Health Emergency | You'll always pay $0 for COVID-19 testing, even if the COVID-19 Public Health Emergency ends. Additionally, during a COVID-19 Public Health Emergency we offer these extra services:<br>• $0 cost share for in-office or telehealth visits with network PCPs<br>• Mental health & psychiatric telehealth services with network providers<br>• You may be eligible for a package of supplies, if you've tested positive, to help prevent the spread of COVID-19 and assist with recovery |
| Meals | When you get home after an inpatient hospital stay, we cover up to 14 home delivered meals. You will be contacted to schedule delivery if eligible and meals will be provided through GA Foods®. |
| Nursing hotline | Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics. |
| Resources For Living® | Resources For Living® helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities, and more. |
| Telehealth | You can receive primary care and urgent care services via a virtual visit for the same cost as an in-person visit.<br><br>Depending on your location, you also have 24/7 access to MinuteClinic® Video Visits. Find out if these visits are available in your area at www.cvs.com/minuteclinic/virtual-care/video-visit. |
| Visitor/travel benefit | Allows you to remain in your plan for up to 12 months when you are outside of our plan's service area.<br><br>You can see an Aetna Medicare participating provider anywhere in the United States who accepts PPO members and pay in-network cost shares. Not all providers participate in the multi-state network. Contact us for help finding a participating provider in the area you're traveling to.<br><br>Plan rules continue to apply. Prior authorizations are required for certain services. |