Summary of Benefits 2021

Aetna Medicare Prime Value (HMO)
H3152 - 080
January 1, 2021 - December 31, 2021

H3152-080

Aetna Medicare Prime Value (HMO) is an HMO plan. This is a Medicare Advantage plan that covers prescription drugs.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service or every limitation and exclusion. The plan's Evidence of Coverage (EOC) provides a complete list of services we cover. The EOC is available at **www.aetnamedicare.com** or you may call us to request a copy.

To join Aetna Medicare Prime Value (HMO), you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Service area: New Jersey: Bergen, Hunterdon, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, Union, Warren

Call us or go online for more information.

1-833-859-6031 (TTY: 711)
October 1 to March 31: 7 days a week from 8 a.m. - 8 p.m. local time
April 1 to September 30: Monday - Friday from 8 a.m. - 8 p.m. local time

www.aetnamedicare.com

H3152.080.1_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

- **Open Access:** This is an HMO open access plan. An open access plan gives members more freedom. Members can visit any in-network provider for covered services without a referral.
- **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 Prime Value (HMO) 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.
- **Limited Network:** This plan offers a local network of select contracted providers. You can see our plan's provider directory at our website at **www.aetnamedicare.com/findprovider**.
- **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
Monthly plan premium	$0
	You must continue to pay your Medicare Part B premium.
Plan deductible	$0
Maximum out-of-pocket amount (does not include prescription drugs)	$7,550
	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
Hospital coverage*	
Inpatient hospital coverage	$295 per day, days 1-6; $0 per day, days 7-90 You pay $0 for days 91 and beyond.
	Our plan covers an unlimited number of days.

Primary benefits	Your costs for in-network care
Outpatient hospital observation services	$325
Outpatient hospital services	$40 - $325
	Lower cost sharing applies for services other than surgery.
Ambulatory surgical center	$325
Doctor visits	
Primary care physician (PCP)	$0
Specialists	$40
Preventive care	$0

Preventive care includes:

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings & counseling
- Bone mass measurements
- Breast cancer screening: mammogram
- Cardiovascular disease screenings
- Cardiovascular behavior therapy
- Cervical & vaginal cancer screenings
- 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
- Nutrition therapy services
- Obesity behavior therapy
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings & counseling
- Tobacco use cessation counseling
- Vaccines: flu, hepatitis B, pneumococcal
- Welcome to Medicare preventive visit
- Yearly wellness visit

Emergency & urgent care	
Emergency care in the United States	$90

Primary benefits	Your costs for in-network care
Urgently needed care in the United States	$65
Emergency & urgently needed care worldwide	Emergency care: $90 Urgently needed care: $90 Ambulance: $285
Diagnostic testing*	
Diagnostic radiology (e.g. MRI & CT scans)	$200
Lab services	$0
Diagnostic tests & procedures	$40
Outpatient x-rays	$50
Hearing, dental, & vision	
For benefits that offer a reimbursement, you can see any licensed provider who is eligible under Medicare.	
Diagnostic hearing exam	$40
Routine hearing exam	$0
	We cover one exam every year. All appointments must 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	$750 reimbursement every year for covered services. Teeth whitening is not covered.
Glaucoma screening	$0
Diagnostic eye exams (including diabetic eye exams)	$0 - $40
	Lower cost sharing: for first diabetic eye exam Higher cost sharing: for all other eye exams

Primary benefits	Your costs for in-network care
Routine eye exam	$0
	We cover one exam every year.
Contacts and eyeglasses	$200 reimbursement every year.
Mental health services*	
Inpatient psychiatric stay	$1,871 per stay
Outpatient mental health therapy (individual)	$40
Outpatient psychiatric therapy (individual)	$40
Skilled nursing*	
Skilled nursing facility (SNF)	$0 per day, days 1-20; $184 per day, days 21-100
	Our plan covers up to 100 days per benefit period.
Therapy*	
Physical and speech therapy	$40
Ambulance & routine transportation	
Ground ambulance (one-way trip)	$285
Air ambulance* (one-way trip)	20%
Routine transportation (non-emergency)	Not Covered
Medicare Part B drugs*	
Chemotherapy drugs	20%
Other Part B drugs	20%

* 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 You pay the full cost of drugs until you reach your deductible.				
The deductible applies to drugs on Tiers 4 and 5.	$195			
Stage 2: Initial coverage 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	29%	29%	N/A	N/A
Stage 3: Coverage gap 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			
Stage 4: Catastrophic coverage 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
Equipment, prosthetics, & supplies*	
Diabetic supplies	0% - 20%
	We only cover OneTouch/Lifescan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices for 0%. 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%
Prosthetics (e.g. braces, artificial limbs)	20%
Substance abuse*	
Outpatient substance abuse (Individual therapy)	$40

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

Additional benefits and services provided by Aetna Medicare Prime Value (HMO)	Benefit information
Fitness	Standard membership at participating SilverSneakers® facilities and access to online wellness related tools, planners, newsletters, and classes, at no extra cost. You can get an at-home fitness kit if you don't live near a participating club or prefer to exercise at home.
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: • Mental health & psychiatric telehealth services with network providers • 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

Additional benefits and services provided by Aetna Medicare Prime Value (HMO)	Benefit information
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.
Over-the-counter items (OTC)	Get over-the-counter health & wellness products by mail or at participating CVS® stores. Our plan pays up to a maximum amount of $30 every three months.
	CVS will manage your OTC benefit. See the OTC catalog for a list of eligible items. You can find the catalog at www.cvs.com/otchs/myorder.
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. 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.

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-833-859-6031 (TTY: 711)**. From October 1 to March 31, you can call us 7 days a week from 8 a.m. - 8 p.m. local time. From April 1 to September 30, we're here Monday through Friday from 8 a.m. - 8 p.m. local time.

Understanding the benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially those services for which you routinely see a doctor. Visit **www.aetnamedicare.com** or call **1-833-859-6031 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding important rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Y0001_NR_0009_21693a_2021_C

Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health family of companies. Aetna and CVS Pharmacy, Inc., which owns CVS® HealthHUB® locations, are part of the CVS Health family of companies.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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. 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. The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary. Medicare's pharmacy network includes limited lower cost, preferred pharmacies in: Rural Kansas, Rural Nebraska, Rural Maine, Rural Michigan, Suburban Arizona, Suburban West Virginia, and Urban Michigan. 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, members please call the number on your ID card, non-members please call 1-833-859-6031 (TTY: 711) or consult the online pharmacy directory at www.aetnamedicare.com/findpharmacy. For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call the number on your ID card if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery. Members who get “Extra Help” are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays. 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.

Y0001_H3152_080_HQ68_SB21_M

2021 Star Ratings

Aetna Medicare - H3152

2021 Medicare Star Ratings

Every year, Medicare evaluates plans based on a 5-star rating system. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Ratings that focus on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2021, Aetna Medicare received the following Overall Star Rating from Medicare.

★★★½
3.5 Stars

We received the following Summary Star Ratings for Aetna Medicare's health/drug plan services:

Health Plan Services:	★★★½ 3.5 Stars
Drug Plan Services:	★★★½ 3.5 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time at 855-275-6627 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

Current members please call 888-268-9800 (toll-free) or 711 (TTY).

Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

Y0001_2021_1090_H3152V2_M