2023 Summary of Benefits

Aetna Medicare Prime (HMO-POS)
H3192 - 001

aetna medicare solutions

Here's a summary of the services we cover from January 1, 2023 through December 31, 2023. Keep in mind: This is just a summary. Need a complete list of what we cover and any limitations? Just visit AetnaMedicare.com where you'll find the plan's Evidence of Coverage (EOC) or you may call us to request a copy.

2023-H3192.001.1

We're here to help

You may have questions as you read through this information. And that's OK — we're here to help.

Not a member yet?

Call 1-833-859-6031 (TTY: 711)
October 1–March 31: 8 AM–8 PM local time, 7 days a week
April 1–September 30: 8 AM–8 PM local time, Monday–Friday

An Aetna® team member will answer your call.

Already a member?

Call 1-833-570-6670 (TTY: 711)
8 AM–8 PM, 7 days a week.

An Aetna team member will answer your call.

H3192-001

Are you eligible to enroll?

To join Aetna Medicare Prime (HMO-POS), you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area

Service area: Illinois: Cook, DuPage, Grundy, Kane, Kankakee, Lake, McHenry, Will

Plan type: Aetna Medicare Prime (HMO-POS) is an POS 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.

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):** A PCP is important for helping to coordinate care and this plan requires you to select a PCP. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can always change the PCP by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Prime (HMO-POS) 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.
- **Network:** Our plan has a network of select providers to provide you with patient-centered care, coordinated services and enhanced provider communication. To locate a network provider you may contact Member Services or search the online provider directory.
- **Prior authorizations:** Your provider 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	$0	
	You must continue to pay your Medicare Part B premium.	
Plan deductible	$0	$0
Maximum out-of-pocket amount (does not include prescription drugs)	$3,950 for in-network services.	$3,950 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.	

H3192-001

Primary benefits	Your costs for in-network care	Your costs for out-of-network care
Hospital coverage*		
Inpatient hospital coverage	$225 per day, days 1-7; $0 per day, days 8-90. You pay $0 for days 91 and beyond.	$275 per day, days 1-7; $0 per day, days 8-90. You pay $0 for days 91 and beyond.
	Our plan covers an unlimited number of days, subject to medical necessity.	
Outpatient hospital observation services	$225 per stay	Not Covered
Outpatient hospital services	$0–$225	Not Covered
	$0 for outpatient hospital services other than surgery $225 for each outpatient hospital surgery	
Ambulatory surgical center	$225	Not Covered
Doctor visits		
Primary care physician (PCP)	$0	Not Covered
Specialists	$25	Not Covered
Preventive care (e.g., certain vaccines, breast cancer screenings, diabetes screenings, etc.)	$0 For a full list of other preventive services available, see the EOC. Some covered services may have a cost associated.	Not Covered
Emergency & urgent care		
Emergency care in the United States	$110	
Urgently needed services in the United States	$40	
Emergency & urgently needed services worldwide	Emergency services: $110 Urgently needed services: $110 Ambulance (ground and air): $255	
Diagnostic testing*		
Diagnostic tests & procedures	$50	Not Covered
Lab services	$0	Not Covered
Diagnostic radiology (e.g., MRI & CT scans)	$160	Not Covered

Primary benefits	Your costs for in-network care	Your costs for out-of-network care
Outpatient x-rays	$10	Not Covered
Hearing, dental, & vision		
Diagnostic hearing exam	$0	Not Covered
Routine hearing exam	$0	Not Covered
	We cover one exam every year. All appointments must be scheduled through NationsHearing.	
Hearing aids	$0 copay up to a maximum amount of $1,000 per ear, every year. You are responsible for any costs over this amount.	You pay the full cost.
	NationsHearing will manage your hearing aid benefits. All hearing aids must be purchased through NationsHearing.	
Dental services (in addition to Original Medicare coverage)	$0 for preventive services (e.g., oral exam, x-rays and cleaning) $0 for comprehensive services (e.g., fillings and extractions)	20% for preventive services (e.g., oral exam, x-rays and cleaning) 20% for comprehensive services (e.g., fillings and extractions)
	Our plan pays up to $3,000 every year for covered services. Cosmetic services, such as teeth whitening, are not covered. You are responsible for any costs over this amount. This plan uses the Aetna Dental PPO Network. Note: Most out-of-network providers will bill us directly. If you use one who won't bill us, you can pay for covered services and ask us to reimburse you.	
Glaucoma screening	$0	Not Covered
Diagnostic eye exams (including diabetic eye exams)	$0–$20	Not Covered
	$0 for diabetic eye exams $20 for all other eye exams	
Routine eye exam (eye refraction)	$0	Not Covered
	We cover one exam every year when obtained from an in-network provider.	
Contacts, eyeglasses and upgrades (in addition to Original Medicare coverage)	Our plan pays up to a maximum amount of $435 every year for prescription eyewear. You are responsible for any costs over this amount. EyeMed will manage your eyewear benefits. If you choose a	

Primary benefits	Your costs for in-network care	Your costs for out-of-network care
	provider outside of the network, services will not be covered.	
Mental health services*		
Inpatient psychiatric stay	$225 per day, days 1-7; $0 per day, days 8-90	Not Covered
Outpatient mental health therapy (individual)	$40	Not Covered
Outpatient psychiatric therapy (individual)	$40	Not Covered
Skilled nursing*		
Skilled nursing facility (SNF)	$10 per day, days 1-20; $196 per day, days 21-100	Not Covered
	Our plan covers up to 100 days per benefit period. Prior authorization is required and patient must meet CMS criteria for medically necessary skilled care to be covered.	
Therapy*		
Physical and speech therapy	$45	Not Covered
Occupational therapy	$40	Not Covered
Ambulance & routine transportation		
Ground ambulance (one-way trip)	$255	Not Covered
Air ambulance* (one-way trip)	20%	Not Covered
Routine transportation (non-emergency)	Not Covered	Not Covered
Medicare Part B drugs* Medicare Part B only covers certain medicines for certain conditions. These medicines are often given to you in your doctor's office. They can include things like vaccines, injections, and nebulizers, among others. They can also include medicines you take at home through special medical equipment.		
Chemotherapy drugs	20%	Not Covered
Other Part B drugs	20%	Not Covered

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

Aetna Medicare Prime (HMO-POS) includes extra benefits. Learn more about these benefits after the prescription drug information.

Prescription drugs

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.)				
Insulins	This plan participates in the Insulin Savings Program providing affordable copayments of up to $35 for a 30-day supply (up to $105 for a 100-day supply) at both preferred and standard pharmacies for select insulins on Tier 3 through the Initial Coverage and Coverage Gap stages of the plan. These copayments apply at retail, mail or long-term care pharmacies. For all other covered insulins on our formulary, this plan provides insulins at affordable copayments of no more than $35 for a 30 day supply (up to $105 for a 100-day supply) at all network pharmacies through all stages of the Part D benefit. These copayments apply at retail, mail or long term care pharmacies.				
Important Message About What You Pay for Vaccines	Our plan covers most Part D vaccines at no cost to you.				
Stage 1: Deductible 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 You pay the costs below until your total drug costs reach $4,660. 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.					
	30-day supply through Retail or Mail		**100-day supply through Retail or Mail**		**31-day supply through Long-Term Care**
	Preferred	**Standard**	**Preferred**	**Standard**	**Standard**
Tier 1: Preferred Generic	$0	$15	$0	$45	$15
Tier 2: Generic	$10	$20	$20	$60	$20
Tier 3: Preferred Brand	$47	$47	$141	$141	$47
Tier 4: Non-Preferred Drug	$100	$100	$300	$300	$100
Tier 5: Specialty	33%	33%	N/A	N/A	33%
Stage 3: Coverage gap Our plan offers some coverage in this stage. The coverage gap lasts until your out-of-pocket drug costs reach $7,400.					

H3192-001

Prescription drugs (Your costs may be lower if you qualify for Extra Help)		
	30-day supply through Retail or Mail	
	Preferred	**Standard**
Tier 1: Preferred Generic	$0	$15
Tier 2: Generic	$10	$20
All other Brand Name and 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 $4.15.	
Brand Name Drugs	You pay the greater of 5% of the cost of the drug or $10.35.	

Other benefits	**Your costs for in-network care**	**Your costs for out-of-network care**
Equipment, prosthetics, & supplies*		
Diabetic supplies	0%–20%	Not Covered
	We only cover OneTouch/Lifescan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices for $0. Note: In case of an approved prior authorization, other brands or types of devices may be covered at 20%.	
Durable medical equipment (e.g., wheelchair, oxygen, continuous positive airway pressure (CPAP))	20%	Not Covered
Prosthetics (e.g., braces, artificial limbs)	20%	Not Covered
Substance abuse*		
Outpatient substance abuse (individual therapy)	$40	Not Covered

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

Additional benefits and services provided by Aetna Medicare Prime (HMO-POS)	**Benefit information**	
	Your costs for in-network care	**Your costs for out-of-network care**
24-Hour Nurse Line	Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	
Chiropractic care*	Medicare-covered services: $20	Medicare-covered services: Not

Additional benefits and services provided by Aetna Medicare Prime (HMO-POS)	Benefit information	
	Your costs for in-network care	Your costs for out-of-network care
	Routine chiropractic care isn't covered. Medicare coverage is limited to fixing a subluxation. This is when one or more of the bones in your spine move out of place.	Covered
Physical fitness program	Physical fitness program: Basic membership at participating SilverSneakers® facilities. Or, if you prefer to exercise at home, you can also get an at-home fitness kit. Additionally, through the SilverSneakers program, you have access to classes and workshops taught by instructors trained in senior fitness, workout videos, a mobile app, and online fitness nutrition tips. You will have access to online enrichment classes to support your health and wellness, as well as your mental fitness.	
Meals	When you get home after an inpatient hospital or skilled nursing stay, we cover up to 14 home-delivered meals over 7 days. You will be contacted to schedule delivery (if eligible) and meals will be provided through GA Foods®.	
Over-the-counter items (OTC)	Get over-the-counter health and wellness products by phone, online, or at select participating stores. Our plan pays up to a maximum amount of $120 quarterly.	
	OTC Health Solutions will manage your OTC benefit. See the OTC catalog for a list of eligible items. You can find the catalog at 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*	This plan covers certain Telehealth services (a cost share may apply). Members should contact their doctor for information on what telehealth services they offer and how to schedule a telehealth visit. Depending on location, members may also have the option to schedule a telehealth visit 24 hours a day, 7 days a week via Teladoc, MinuteClinic Video Visit, or other providers that offer telehealth services covered under your plan.	

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

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 Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs 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 member services 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. Aetna Medicare's pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Suburban Illinois, Urban Kansas, Suburban Michigan, Rural Michigan, Urban Michigan, Urban Missouri, Rural North Dakota, Suburban Utah, Suburban West Virginia and Suburban Wyoming. 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 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.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

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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 AM to 8 PM local time. From April 1 to September 30, we're here Monday through Friday from 8 AM to 8 PM local time.

Understanding the benefits

- ☐ The Evidence of Coverage (EOC), provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **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.
- ☐ Review the formulary to make sure your drugs are covered.

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 may change on January 1, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for **certain covered services**, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-570-6670. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-570-6670. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-570-6670。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-570-6670。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-570-6670. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-570-6670. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-570-6670. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-570-6670. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-570-6670. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-570-6670. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-570-6670 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-570-6670. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-570-6670. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-570-6670. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-570-6670. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-570-6670. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-570-6670. にお電話ください。日本語を話す人者 が支援いたします。これは無料のサー ビスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-833-570-6670. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, our health plan provides auxiliary aids and services, free of charge, when necessary, to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Our health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, visit our website, call the phone number listed in this material or on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

傳統漢語(中文) (CHINESE): 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。