The Aetna Medicare Premier (PPO) plan (H5521-081) for 2025 features a $0 monthly premium, although members must continue to pay their Medicare Part B premium. Eligibility requires individuals to have Medicare Part A and B and reside in designated counties in North Carolina. The plan provides access to both in-network and out-of-network providers, with higher costs associated with out-of-network care. Members can see specialists without a referral, but prior authorization is necessary for certain services and medications. The plan has a $0 deductible and a maximum out-of-pocket (MOOP) limit of $5,900 for in-network services and $6,900 for combined in- and out-of-network services, after which 100% of covered medical services are paid by the plan.

Inpatient hospital stays require a copay of $300 per day for the first six days, with no charge for days 7-90; out-of-network costs are $400 per day for the first six days. Outpatient service copays range from $35 to $300 depending on the service and provider network, while preventive services are covered at a $0 copay. Emergency care incurs a $125 copay regardless of network status, and diagnostic services often require prior authorization, with costs varying by provider and service type. Hearing services include a $30 copay for diagnostic exams and an annual allowance of $1,250 for hearing aids through network providers. Dental services have a $0 copay for in-network covered services, with a $1,500 annual allowance, while out-of-network services incur 50% coinsurance. Vision services cover one routine eye exam annually and provide a $200 allowance for eyewear.

Mental health services require prior authorization, with inpatient psychiatric stays costing $286 per day for the first eight days. Skilled nursing facility care is covered for up to 100 days, with copays based on the length of stay. Ambulance services have a $275 copay for ground transport, and routine non-emergency transportation is not covered. Medicare Part B drugs require prior authorization, with costs ranging from 0% to 20% coinsurance. For Medicare Part D drugs, there is a $250 deductible for certain tiers, with copays varying by tier and pharmacy type. The out-of-pocket maximum for yearly Part D costs is $2,000, after which the plan covers the full cost of covered drugs, and insulin products are capped at $35 for a one-month supply.

Additional benefits include a $30 copay for in-network acupuncture visits and a $20 copay for chiropractic services, both limited to Medicare-covered treatments. Diabetic supplies are covered with 0% coinsurance for preferred products and 20% for non-preferred items. The plan also offers a fitness benefit with a $0 copay for a basic membership to participating SilverSneakers® facilities, and home health care services are available with a $0 copay in-network, subject to prior authorization. Members are eligible for a meal benefit post-discharge, receiving up to 14 meals for a week to support recovery. Durable medical equipment (DME) incurs 0% to 20% coinsurance, often requiring prior authorization. An over-the-counter (OTC) benefit allows for $45 quarterly to purchase health products, with unused amounts not rolling over. The plan includes a visitor/travel program allowing members to receive in-network cost shares while traveling within the U.S.

The policy emphasizes the necessity of prior authorization for certain services and clarifies that out-of-network providers are not obligated to treat members except in emergencies. Members must continue paying their Medicare Part B premium, and benefits, premiums, and copayments may change annually. The plan is subject to contract renewal, and members are encouraged to review the Evidence of Coverage for detailed information on benefits, exclusions, and limitations. Additionally, the document outlines the availability of free translation services for individuals with questions regarding health or medication plans, accessible by calling 1-833-570-6670. It ensures compliance with federal civil rights laws, prohibiting discrimination based on race, color, national origin, age, disability, or sex, and provides auxiliary aids and services at no charge for effective communication. Grievances regarding discrimination or inadequate service can be filed with the Grievance Department or Customer Service, and civil rights complaints may be submitted to the U.S. Department of Health and Human Services, Office for Civil Rights.