2022 Aetna Medicare Advantage Plan Information

Thank you for your interest in applying for the Aetna Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Aetna within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

Star Rating: HMO / PPO / HMO (Prime & Value)
Application Download
Summary of Benefits: Choice II Plan PPO / Choice Plan PPO / Eagle PPO / Plus Plan PPO / Prime Plan HMO / Value Plan HMO
Provider Search
Pharmacy Search
Formulary

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: http://www.medicare-texas.net

Y0062_MULTIPLAN_CDA INSURANCE Texas 2022 (Pending)

Summary of Benefits 2022

Aetna Medicare Prime Plan (HMO)
H4523 - 021
January 1, 2022 - December 31, 2022

Aetna Medicare Prime Plan (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 **AetnaMedicare.com** or you may call us to request a copy. To join Aetna Medicare Prime Plan (HMO), you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Service area: Texas: Collin, Dallas, Denton, Tarrant

2022-H4523.021.1

Call us or go online for more information.

Not a member yet? Call 1-833-859-6031 (TTY: 711)
October 1 to March 31: 7 days a week from 8 AM to 8 PM local time
April 1 to September 30: Monday - Friday from 8 AM to 8 PM local time
Already a member? Call 1-833-570-6670 (TTY: 711)
8 AM to 8 PM, 7 days a week

AetnaMedicare.com

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.
- **Referrals:** In most cases, your PCP must give you approval before you can use other providers in the network. You don't need a referral for emergency or urgently needed care.
- **Network:** Our plan has joined with Baylor Scott & White facilities, the Methodist Health System , & HCA physicians, just to name a few to provide you with patient centric care.
- **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
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)	$5,900
	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	$300 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.
Outpatient hospital observation services	$275 per stay

Primary benefits	Your costs for in-network care		
Outpatient hospital services	$40 - $275		
	Lower cost sharing applies for services other than surgery.		
Ambulatory surgical center	$275		
Doctor visits			
Primary care physician (PCP)	$0		
Specialists	$40		
Preventive care	$0		
	Preventive care includes: • Abdominal aortic aneurysm screenings • Alcohol misuse screenings and counseling • Bone mass measurements • Breast cancer screening: mammogram • Cardiovascular disease screenings • Cardiovascular behavior therapy • Cervical and 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 and counseling • Tobacco use cessation counseling • Vaccines: Covid-19, 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	$0 - $65
	Lower cost sharing: for services provided by your primary care physician in their office Higher cost sharing: for services performed by a provider other than your primary care physician
Emergency & urgently needed care worldwide	Emergency care: $90 Urgently needed care: $90 Ambulance: $270
Diagnostic testing*	
Diagnostic radiology (e.g. MRI & CT scans)	$0 - $325
	Lower cost sharing: for services provided by your primary care physician in their office Higher cost sharing: for services performed by a provider other than your primary care physician
Lab services	$0
Diagnostic tests & procedures	$40
Outpatient x-rays	$40
Hearing, dental, & vision	
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 $500 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.

Primary benefits	Your costs for in-network care
Dental services (in addition to Original Medicare coverage)	$0 for preventive services (e.g. oral exam, x-rays and cleaning) 50% for comprehensive services. Comprehensive services include fillings and extractions.
	Our plan pays up to a maximum amount of $1,000 every year for preventive and comprehensive services. You are responsible for any costs over this amount.
	If you choose a provider outside of the Aetna Dental® PPO Network, services will not be covered.
Glaucoma screening	$0
Diagnostic eye exams (including diabetic eye exams)	$0 - $40
	Lower cost sharing: for diabetic eye exams Higher cost sharing: for all other eye exams
Routine eye exam	$0
	We cover one exam every year when obtained by an in-network provider.
Contacts and eyeglasses (in addition to Original Medicare coverage)	Our plan pays up to a maximum amount of $100 every year for prescription eyewear. You are responsible for any costs over this amount. EyeMed will manage your eyewear benefits. If you choose a provider outside of the network, services will not be covered.
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; $188 per day, days 21-100
	Our plan covers up to 100 days per benefit period.

Primary benefits	Your costs for in-network care
Therapy*	
Physical and speech therapy	$40
Occupational therapy	$40
Ambulance & routine transportation	
Ground ambulance (one-way trip)	$270
Air ambulance* (one-way trip)	$270
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.

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

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 3, 4 and 5.	$250

Prescription drugs (Your costs may be lower if you qualify for Extra Help)					
Stage 2: Initial coverage You pay the costs below until your total drug costs reach $4,430. 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	$0	$20	$0	$60	$20
Tier 3: Preferred Brand	$47	$47	$141	$141	$47
Tier 4: Non-Preferred Drug	$100	$100	$300	$300	$100
Tier 5: Specialty	28%	28%	N/A	N/A	28%

Stage 3: Coverage gap Our plan offers some coverage in this stage. The coverage gap lasts until your out-of-pocket drug costs reach $7,050.		
	30-day supply through Retail or Mail	
	Preferred	**Standard**
Tier 1: Preferred Generic	$0	$15
Tier 2: Generic	$0	$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 $3.95.
Brand Name Drugs	You pay the greater of 5% of the cost of the drug or $9.85.

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. Note: In case of an approved medical exception, other brands may be 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 Plan (HMO)	Benefit information
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
Fitness	Basic membership at participating SilverSneakers® facilities and access to online wellness related tools, planners, newsletters and classes, at no extra cost. You can request an at-home fitness kit through SilverSneakers® if you don't live near a participating club or prefer to exercise at home.

Additional benefits and services provided by Aetna Medicare Prime Plan (HMO)	Benefit information
Over-the-counter items (OTC)	Get over-the-counter health and wellness products by mail or at participating CVS® stores. Our plan pays up to a maximum amount of $75 every quarter.
	OTC Health Solutions will manage your OTC benefit. See the OTC catalog for a list of eligible items. You can find the catalog at https://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, physician specialist, mental health and urgent care services via a virtual visit. 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 provider that offers telehealth services covered under your plan. Members can access Teladoc at https://www.teladoc.com/aetna/ or by calling 1-855-TELADOC (1-855-835-2362) (TTY: 711). Members can find out if MinuteClinic Video Visit are available in their area at: https://www.cvs.com/minuteclinic/virtual-care/videovisit.

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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 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, Rural Michigan, Urban Michigan, Urban Missouri and Suburban West Virginia. 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. SilverSneakers is a registered trademark of Tivity Health, Inc.

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