2023 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 (Value)
Application Download
Summary of Benefits: Choice Plan PPO / Eagle II Plan PPO / Eagle Plan PPO / Premier Plan HMO / Prime Plan HMO / Freedom PPO / Value Plan PPO
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 2023 (Pending)

2023 Summary of Benefits

Aetna Medicare Select Plan (HMO)
H8332 - 003

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-H8332.003.1

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.

H8332-003

Are you eligible to enroll?

To join Aetna Medicare Select Plan (HMO), you must:

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

Service area: Texas: Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jefferson, Liberty, Montgomery, Orange, San Jacinto, Waller

Plan type: Aetna Medicare Select Plan (HMO) is an HMO plan. This is a Medicare Advantage plan that covers prescription drugs.

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:** 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 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
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)	$3,900
	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	$400 per stay
	Our plan covers an unlimited number of days, subject to medical necessity.
Outpatient hospital observation services	$175 per stay
Outpatient hospital services	$20–$175
	$20 for outpatient hospital services other than surgery $175 for each outpatient hospital surgery
Ambulatory surgical center	$175
Doctor visits	
Primary care physician (PCP)	$0
Specialists	$20
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.
Emergency & urgent care	
Emergency care in the United States	$110
Urgently needed services in the United States	$0–$60
	$0 for services provided by your primary care physician in their office $60 for services performed by a provider other than your primary care physician
Emergency & urgently needed services worldwide	Emergency services: $110 Urgently needed services: $110 Ambulance (ground and air): $255
Diagnostic testing*	
Diagnostic tests & procedures	$40
Lab services	$0
Diagnostic radiology (e.g., MRI & CT scans)	$225
Outpatient x-rays	$20
Hearing, dental, & vision	

Primary benefits	Your costs for in-network care
Diagnostic hearing exam	$20
Routine hearing exam	$0
	We cover one exam every year. All appointments must be scheduled through NationsHearing.
Hearing aids	$0 copay 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 (in addition to Original Medicare coverage)	$0 for preventive services (e.g., oral exam, x-rays and cleaning) 20%–50% for comprehensive services. Comprehensive services include fillings, extractions, crowns, root canals, dentures and oral surgery.
	Our plan pays up to a maximum amount of $3,000 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
Routine eye exam (eye refraction)	$0
	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 $250 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

Primary benefits	Your costs for in-network care
Skilled nursing*	
Skilled nursing facility (SNF)	$10 per day, days 1-20; $196 per day, days 21-100
	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	$20
Occupational therapy	$20
Ambulance & routine transportation	
Ground ambulance (one-way trip)	$255
Air ambulance* (one-way trip)	$255
Routine transportation (non-emergency)	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%
Other Part B drugs	20%

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

Aetna Medicare Select Plan (HMO) 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.)				
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	$150				
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	30%	30%	N/A	N/A	30%
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.					
	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
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 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%
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 Select Plan (HMO)	Benefit information
	Your costs for in-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 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.
Fall prevention	Our plan pays up to a maximum amount of $150 every year for certain clinically appropriate home and bathroom safety devices that can improve your ability to move around your home. Your Aetna Care Team will determine your eligibility for this benefit.
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

Additional benefits and services provided by Aetna Medicare Select Plan (HMO)	Benefit information Your costs for in-network care
	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.
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 $165 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.

H8332-003

Uniform Flexibility

Eligibility Requirements:
If you are diagnosed by a plan provider with one of the chronic condition listed below, you may be eligible for additional benefits to help you manage your condition. Qualified members will be identified and informed of the additional services for which they qualify.

- Hypertension
- Hyperlipidemia

Over-the-Counter (OTC) blood pressure cuff
For eligible members with a diagnosis of hypertension:

- Our plan has contracted with OTC Health Solutions to provide you with one blood pressure monitoring device per year. A care team member will work with you to select and order your device from a pre-approved list.

Transportation services (non-emergency)
For eligible members with a diagnosis of hypertension or hyperlipidemia:

- Coverage is provided for up to 24 one-way trips every year. Trips are provided via Taxi, Rideshare Services, Van. All trips are subject to a mileage limit of up to 60 miles each trip, unless pre-approved by the plan. Our plan has partnered with Access2Care to provide this benefit. You will need to contact Access2Care at least 48 hours in advance to schedule a trip.

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, 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.

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

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