January 1, 2016 – December 31, 2016

Summary of Benefits

Aetna Medicare Elite Plan (HMO)
H5793-011

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January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Aetna Medicare Elite Plan (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Aetna Medicare Elite Plan (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://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.

Sections in this booklet

- Things to Know About **Aetna Medicare Elite Plan (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-855-338-7027, TTY: 711.

Este documento está disponible en otros formatos como Braille y en letra grande.
Este documento puede estar disponible en un idioma diferente al inglés. Para información adicional, llámenos al 1-855-338-9533, TTY 711.

Things to Know About Aetna Medicare Elite Plan (HMO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time.

Aetna Medicare Elite Plan (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-282-5366, TTY: 711.
- If you are not a member of this plan, call toll-free 1-855-338-7027, TTY: 711.
- Our website: http://www.aetnamedicare.com

Who can join?

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

Our service area includes the following counties in Connecticut: Hartford, Litchfield, and Tolland.

Which doctors, hospitals, and pharmacies can I use?

Aetna Medicare Elite Plan (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider directory at our website (http://www.AetnaMedicareDocFind.com).

You can see our plan's pharmacy directory at our website (http://www.aetnamedicare.com/findpharmacy2016).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.aetnamedicare.com/2016formulary.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits

January 1, 2016 – December 31, 2016

	Aetna Medicare Elite Plan (HMO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services. $1,000 per year for in-network services. This plan does not have a deductible for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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

Covered Medical and Hospital Benefits	

Note:

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Outpatient Care and Services	
Acupuncture	Not covered
Ambulance[1]	$300 copay
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay The $1,000 Annual In Network Deductible does not apply to these services.

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Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $35 copay Preventive dental services: • Cleaning: $0 copay • Dental x-ray(s): $0 copay • Oral exam: $0 copay Our plan pays up to $175 every year for preventive dental services. Our plan pays up to $175 a year for dental services. You can see any licensed dental provider. You will need to pay the dentist at the time of service and send us an itemized bill with a request for payment. The $1,000 Annual In Network Deductible does not apply to these services.
Diabetes Supplies and Services[1,2]	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing You pay a $0 copayment for glucose monitors and diabetic test strips from our preferred vendor, OneTouch/LifeScan. You will pay 20% of the cost of glucose monitors and diabetic test strips from non-preferred vendors. The $1,000 annual in-network deductible does not apply to these costs.
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): $150 copay Diagnostic tests and procedures: $40 copay Lab services: $10 copay Outpatient x-rays: $20 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost The $1,000 Annual In Network Deductible does not apply to Diagnostic Tests, Lab and X-Rays services. It does apply to Radiology Services (such as CT Scans, MRI's, MRA's, etc.) and Therapeutic Radiology services.
Doctor's Office Visits[2]	Primary care physician visit: $10 copay Specialist visit: $35 copay The $1,000 Annual In Network Deductible does not apply to these services.
Durable Medical Equipment	20% of the cost

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(wheelchairs, oxygen, etc.)[1]	The $1,000 Annual In Network Deductible does not apply to these services.
Emergency Care	$75 copay If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. The $1,000 Annual In Network Deductible does not apply to these services.
Foot Care *(podiatry services)*[2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 copay The $1,000 Annual In Network Deductible does not apply to these services.
Hearing Services[2]	Exam to diagnose and treat hearing and balance issues: $35 copay Routine hearing exam (for up to 1 every year): $0 copay Hearing aid fitting/evaluation: $35 copay Hearing aid: $0 copay Our plan pays up to $800 every three years for hearing aids. You pay a $0 copay for routine hearing exams. We pay up to $800 every 3 years toward the cost of hearing aids. The $1,000 Annual In Network Deductible does not apply.
Home Health Care[1]	You pay nothing The $1,000 Annual In Network Deductible does not apply to these services.
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $1,528 copay per stay Outpatient group therapy visit: $40 copay

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Mental Health Care[1]	Outpatient individual therapy visit: $40 copay Inpatient mental health hospitalization: You pay your cost share per admission; The $1,000 Annual In Network Deductible does not apply to outpatient group and individual therapy visits.
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $35 copay Occupational therapy visit: $35 copay Physical therapy and speech and language therapy visit: $35 copay The $1,000 Annual In Network Deductible does not apply to these services.
Outpatient Substance Abuse[1]	Group therapy visit: $35 copay Individual therapy visit: $35 copay The $1,000 Annual In Network Deductible does not apply to these services.
Outpatient Surgery[1]	Ambulatory surgical center: $150 copay Outpatient hospital: $35-150 copay, depending on the service The minimum copay will apply to Medicare-covered outpatient hospital services other than surgery. The maximum copay will apply to Medicare-covered outpatient hospital surgery.
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 20% of the cost Related medical supplies: $35 copay The $1,000 Annual In Network Deductible does not apply to these services.
Renal Dialysis[1]	20% of the cost
Transportation	Not covered
Urgently Needed Services	$10-35 copay, depending on the service The minimum copay would apply for urgently needed care received by a PCP that is assigned to or selected by the member, the maximum copay would apply for urgently needed care received at an Urgent Care facility. The $1,000 Annual In Network Deductible does not apply to these services.

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Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-35 copay, depending on the service Routine eye exam (for up to 1 every year): $0 copay Contact lenses: $0 copay Eyeglasses (frames and lenses): $0 copay Eyeglasses or contact lenses after cataract surgery: $0 copay Our plan pays up to $125 every two years for contact lenses and eyeglasses (frames and lenses). $0 copay for Medicare-covered glaucoma screenings and routine eye exams, and a higher copay for non-routine Medicare Covered eye exams. This plan has an eyewear allowance of $125 every 2 years. The $1,000 Annual In Network Deductible does not apply.
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. The $1,000 Annual In Network Deductible does not apply to these services.

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Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. The $1,000 Annual In Network Deductible does not apply to these services.
Inpatient Care	
Inpatient Hospital Care [1]	Our plan covers an unlimited number of days for an inpatient hospital stay. • $600 copay per stay • You pay nothing per day for days 91 and beyond You pay your cost share per admission
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100
Prescription Drug Benefits	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost
Initial Coverage	You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing**

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$14 copay	$28 copay	$42 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay

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Initial Coverage

Tier	One-month supply	Two-month supply	Three-month supply
Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost
Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$5 copay	$10 copay	$15 copay
Tier 2 (Generic)	$13 copay	$26 copay	$39 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost
Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered

Standard Mail Order Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$14 copay	$28 copay	$42 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Brand)	50% of the cost	50% of the cost	50% of the cost
Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay

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Coverage Gap	for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.