2024 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 download and save documents

Star Rating: HMO / PPO
Online Application
Summary of Benefits: Preferred 380 / SmartFit 431 / Elite 007 / Value 001 / Eagle 330 / Value 010 / Choice 393 / Elite 009 / Extra Value 003 / Prime 008 / Preferred 380 / Choice 127 / Select 128 / Choice 379 / SmartFit 423 / Extra Value 149 / Value Plus 165 / SmartFit Elite 013 / Elite 006 /
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: https://medicare-washington.com

Y0062_MULTIPLAN_CDA INSURANCE Washington 2024 (Pending)

2024 Summary of Benefits

Aetna Medicare Elite Plan (HMO-POS)
H3748 - 006

aetna®

Here's a summary of the services we cover from January 1, 2024 through December 31, 2024. Keep in mind: This is just a summary. Need a complete list of what we cover and any limitations? Just visit AetnaMedicare.com/H3748-006 where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

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 to 8 PM, 7 days a week
April 1–September 30: 8 AM to 8 PM, Monday–Friday
An Aetna® team member will answer your call.

Already a member?

Call 1-833-570-6670 (TTY: 711)
8 AM to 8 PM, 7 days a week
An Aetna team member will answer your call.

2024-H3748.006.1

Are you eligible to enroll?

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

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:
  Washington: Clark, Cowlitz

What you should know

- **Plan type:** Aetna Medicare Elite Plan (HMO-POS) is an HMO plan. This is a Medicare Advantage plan that covers prescription drugs.
- **Primary Care Physician (PCP):** A PCP is important to help coordinate your care. We require 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 change your PCP anytime by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Elite Plan (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.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Contact information:** To get more information about some benefits, please see the Contact quick reference chart at the end of this document.
- **Provider directory:** View your provider directory at AetnaMedicare.com/H3748-006.

Plan premium, deductible, and maximum out-of-pocket (MOOP)

Out-of-pocket costs	
Monthly premium	$0 You must continue to pay your Medicare Part B premium.
Plan deductible	$1,000* for certain in-network services. Your deductible is what you'll pay before we begin to pay for services. The plan deductible applies to the following services provided by an in-network provider: inpatient hospital coverage, inpatient services in a psychiatric hospital, skilled nursing facility, therapeutic radiology, outpatient hospital services (including observation), ambulatory surgical center and dialysis.
MOOP	$5,500 for in-network services Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.

Medical and hospital benefits

Hospital coverage

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Inpatient (unlimited number of days)	$325 per day, days 1-5; $0 per day, days 6-90 after your plan deductible; $0 for additional days
Outpatient hospital observation services	$325 per stay after your plan deductible
Outpatient hospital	$225 after your plan deductible
Ambulatory surgical center	$160 after your plan deductible

Doctor visits

Benefit	Your costs in our plan
PCP	$0
Specialist	$35

Preventive, emergency and urgent care

Benefit	Your costs in our plan
Preventive care	$0
	For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.
Emergency and urgent care (inside the U.S.)	$120 for emergency care $35 for urgent care
Emergency and urgent care, including ambulance (outside the U.S.)	$120 for emergency care $120 for urgent care $240 for ambulance

Diagnostic services, labs, imaging

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Diagnostic tests and procedures	$0
Lab services	$0
Diagnostic radiology services, such as MRI	$195
Outpatient x-rays	$0

Hearing services

Benefit	Your costs in our plan
Diagnostic hearing exam	$0
Routine hearing exam	$0 You get one routine hearing exam every year with a provider in the NationsHearing network.
Hearing aids	You get an annual benefit amount (allowance) up to a maximum amount of $2,000 per ear, every year. This benefit amount can only be used to purchase hearing aids through a NationsHearing network provider. If the cost is over the benefit amount, you pay the difference.

Dental services

Benefit	Your in-network costs	Your out-of-network costs
Dental services	$0 for preventive services including oral exams, bitewing x-rays and cleanings $0 for comprehensive services including things like fillings, extractions, crowns, root canals, dentures, and implants $2,100 annual benefit amount (allowance). This is the total amount that will be paid for covered preventive and comprehensive services combined. You are responsible for any costs over this amount. This benefit uses the Aetna Dental PPO Network, which is different from your medical network. You can use a provider in or out of the Aetna Dental PPO Network. However, in-network providers agree to bill us directly so you won't have to pay the provider and then submit a reimbursement request - and you may save money. To find a provider and learn more about this benefit visit AetnaMedicare.com/H3748-006	20% for preventive services including oral exams, bitewing x-rays and cleanings 20% for comprehensive services including things like fillings, extractions, crowns, root canals, dentures, and implants

Vision services

Benefit	Your costs in our plan
Diagnostic eye exam (includes diabetic eye exams)	$0
Glaucoma screening	$0
Routine eye exam	$0 Our plan covers one exam every year when obtained from an in-network provider.
Contacts and eyeglasses	You get a vision eyewear benefit amount (allowance) up to $320 every year for covered prescription eyewear. This eyewear benefit is set up as a yearly direct member reimbursement (DMR). You can use your benefit amount at any licensed vision provider in the U.S. However, if you see an EyeMed provider, they may provide a discount and automatically apply your benefit amount so you won't have to submit for reimbursement. If you see a provider outside of the network, you will have to pay at the time of service and then submit for reimbursement.

Mental health services

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Inpatient psychiatric hospital stay	$325 per day, days 1-5; $0 per day, days 6-90 after your plan deductible
Outpatient mental health therapy	$40
Outpatient psychiatric therapy	$40

Skilled nursing facility (SNF) and therapy

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification. Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

Benefit	Your costs in our plan
SNF care	$0 per day, days 1-20; $196 per day, days 21-100 after your plan deductible
	Our plan covers up to 100 days per benefit period.
Physical and speech therapy	$20
Occupational therapy	$20

Ambulance and routine transportation

Your doctor often needs approval from us before we cover non-emergency air ambulance. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Ambulance (ground or air, one-way trip)	$240
Routine, non-emergency transportation	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 using special medical equipment. Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Chemotherapy drugs	0% - 20% Minimum cost share ensures member cost sharing does not exceed the adjusted Medicare coinsurance for Part B rebatable drugs
Other Part B drugs	0% - 20% Minimum cost share ensures member cost sharing does not exceed the adjusted Medicare coinsurance for Part B rebatable drugs

Medicare Part D drugs

Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes.

Prescription drugs (Your costs may be lower if you qualify for Extra Help)

Formulary name	B2: Some drugs require **prior authorization**. This means you must get approval from us first before we'll cover it.

Deductible phase

You'll pay the plan's negotiated drug cost up to the deductible limit.

This plan doesn't have a deductible, so your coverage begins at the Initial coverage phase.	$0

Initial coverage phase

The plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription filled until your total drug costs reach $5,030. 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.

One-month Supply

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Preferred Retail 30-day	Standard Retail 30-day	Preferred Mail 30-day	Standard Mail 30-day	Standard Long-Term Care (LTC) 31-day
Tier 1: Preferred Generic	$0	$5	$0	$5	$5
Tier 2: Generic	$5	$10	$0	$10	$10
Tier 3: Preferred Brand	$47	$47	$47	$47	$47
Tier 4: Non-Preferred Drug	$100	$100	$100	$100	$100
Tier 5: Specialty	33%	33%	33%	33%	33%

Long-term Supply

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Preferred Retail 100-day	Standard Retail 100-day	Preferred Mail 100-day	Standard Mail 100-day
Tier 1: Preferred Generic	$0	$15	$0	$15
Tier 2: Generic	$10	$30	$0	$30
Tier 3: Preferred Brand	$141	$141	$141	$141
Tier 4: Non-Preferred Drug	$300	$300	$300	$300

	Preferred Retail 100-day	Standard Retail 100-day	Preferred Mail 100-day	Standard Mail 100-day
Tier 5: Specialty	A long-term supply is not available for drugs on Tier 5.			
Coverage gap phase Our plan offers additional coverage in the gap. This phase lasts until your yearly out-of-pocket drug costs reach $8,000.				
	Preferred Retail 30-day	**Standard Retail 30-day**	**Preferred Mail 30-day**	**Standard Mail 30-day**
Tier 1: Preferred Generic	$0	$5	$0	$5
Tier 2: Generic	$5	$10	$0	$10
All other brand name and generic drugs	25% of the plan's cost	25% of the plan's cost	25% of the plan's cost	25% of the plan's cost
Catastrophic coverage phase In this phase, the plan pays the full cost for your covered Part D drugs.				
Generic and brand name drugs	$0			
Insulins and vaccines				
Important message about what you pay for Part D vaccines	Our plan covers most vaccines at no cost to you.			
Important message about what you pay for Part D insulins	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or Part D phase you are in.			
Check your formulary guide for a list of covered insulins and vaccines				

Other covered benefits

Complementary and alternative medicine (CAM)

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Acupuncture	$35 for Medicare-covered care Medicare coverage is limited to services to treat chronic low back pain. Routine acupuncture care isn't covered.
Chiropractic care	$10 for Medicare-covered care $10 for routine care Medicare coverage is limited to fixing a subluxation. This is when one or more of the bones in your spine move out of place. For routine services, we also cover up to twelve visits every year as necessary to meet your individual needs.
Massage therapy	$10 Therapeutic massage uses a variety of massage techniques to relieve or reduce chronic muscle or joint pain. We cover up to twelve visits every year as necessary to meet your individual needs.
Naturopathic physician services	$10 Naturopathic medicine combines modern and traditional approaches with more natural and wellness-based methods of treatment. We cover up to 12 visits every year as necessary to meet your individual needs.

Diabetic supplies

We cover blood glucose monitors and diabetic test strips from **OneTouch®/LifeScan.**
Keep in mind: You'll pay more for other brands.
Your doctor may need approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan

Diabetic supplies	0% – 20% 0% for OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices 20% for non-OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices (prior authorization may be required)

Fitness program

Benefit	Your costs in our plan
Physical and memory fitness	$0 You're eligible for a basic membership at SilverSneakers participating facilities. If you prefer to exercise at home, you can also access online classes or get an at-home fitness kit. This membership also includes classes and workshops taught by instructors trained in senior fitness, workout videos, a mobile app, and online fitness nutrition tips. You will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness. **Fitness allowance**: You also get a direct member reimbursement (DMR) allowance of $600 per year. You can be reimbursed toward: • Fees paid for aerobic/fitness activities or membership fees to a qualified fitness club that does not participate with SilverSneakers. • Activity fees such as pickleball fees, golf green fees, ski/lift passes and fees, National and State park fees, bowling, yoga, stretching, dance classes, and fees associated with extra features at SilverSneakers facilities. • Activity supplies such as camping tents, hiking poles, and fishing rods. • Weights and fitness supplies such as exercise peddlers, yoga mats, exercise bands. • Wearable items such as athletic shoes and tracking devices.

	This is a direct member fitness reimbursement (DMR) benefit. That means you pay up front for qualified fitness services/activities and submit for reimbursement. You'll also have access to BrainHQ, an online memory fitness program. It contains brain exercises and assessments, as well as a library of information on activities that contribute to brain health. You can log in and use BrainHQ from your internet-connected computer, tablet, or smartphone (or all three) on a schedule that works best for you.

Foot care (podiatry services)

Benefit	Your costs in our plan
Foot exams and treatment	$35 for Medicare-covered care

Home care and support

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Home health care	$0
Meals	$0 Our plan covers up to 14 meals over 7 days after you're discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility. Upon discharge, you'll be contacted by NationsMarket to schedule delivery.

Medical equipment and supplies

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Durable medical equipment (DME), like CPAP* machines, wheelchairs and oxygen	20%
Prosthetics, such as braces and artificial limbs	20%

*CPAP stands for “continuous positive airway pressure.”

Resources For Living®

Benefit	
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.

Substance abuse

Your doctor may need approval from us before we cover these services. This is called **prior authorization** or pre-certification.

Benefit	Your costs in our plan
Outpatient substance abuse therapy	$40

Visitor/travel benefit

Plan rules continue to apply. You will need to choose a PCP where you are receiving care. **Prior authorizations** are required for certain services.

Benefit	
Visitor/travel program: Travel Advantage	Allows you to remain in your plan for up to 12 months when you are outside our plan's service area. You can see an Aetna Medicare participating provider anywhere in the United States (except California) who accepts HMO members and pay in-network cost shares. Not all providers participate in the multi-state network. Contact us for help finding a participating provider in the area you're traveling to.

24-Hour Nurse Line

Talk to a registered nurse anytime, day or night.

Benefit	Your costs in our plan
Nurse Line	$0

Contact quick reference

Contact name	Phone number (TTY: 711)	Website
Aetna: Before you enroll	**1-833-859-6031**	**AetnaMedicare.com**
Aetna: After you enroll	Member Services: **1-833-570-6670**	**AetnaMedicare.com/H3748-006**
Your agent/broker (use this space to write down your agent/broker's phone number)		
Find a network doctor, hospital, or pharmacy	**1-833-570-6670**	**AetnaMedicare.com/findprovider**
24-Hour Nurse Line	**1-855-493-7019**	Please call
Aetna (dental)	**1-833-570-6670**	**AetnaMedicare.com/dental**
BrainHQ (memory fitness)	**1-888-845-0565 (TTY: 711)**	**Aetna.BrainHQ.com**
EyeMed (vision)	**1-844-486-3485 (TTY: 711)**	**AetnaMedicareVision.com**
NationsHearing	**1-877-225-0137 (TTY: 711 for the hearing and speech impaired)**	**Aetna.NationsBenefits.com/Hearing**
OneTouch/LifeScan	**1-877-764-5390 Brochure code: 123AET200**	**OneTouch.orderpoints.com**
SilverSneakers	**1-888-423-4632 (TTY/TDD: 711)**	**SilverSneakers.com**

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 D-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 plan 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 and/or pharmacy network may change at any time. You will receive notice when necessary.

The Aetna Medicare pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Rural North Dakota 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 1-833-570-6670 (TTY: 711) 8 AM to 8 PM, 7 days a week 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.

Participating 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.

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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

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