

# MEDICARE ADVANTAGE / PDP ▾

## Plan Details



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### Aetna Medicare

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**\$30.90**

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Plan: **Aetna Medicare Advantra Cares (HMO D-SNP)**

Max Out of Pocket:

Annual Drug Deductible: **\$130.00**

ID: **H3959-35-0**

Star Rating: **4.5**

Plan Type: **Local HMO**

Part B Reduction: **n/a**

Effective Year: **2021**

City: **n/a**

State: **n/a**

Zip: **n/a**

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### Monthly premium deductible and limits on how much you pay for covered services

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\$140 in-network deductible. \$7550 in-network out of pocket maximum.

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### Acupuncture

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Not covered

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### Ambulance

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20% coinsurance, waived if admitted to hospital

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### Chiropractic care

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Not covered. 20% coinsurance for Medicare-covered visits.

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### Dental services

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20% coinsurance for Medicare-covered services. \$0 copay for non-routine services. \$0 copay for prophylaxis (cleaning). \$0 copay for oral exams. \$0 copay for fluoride treatments. \$0 copay for dental x-rays. Max of \$4000 combined preventive and comprehensive dental benefits for this plan every year.

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### **Diabetes supplies and services**

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20% coinsurance for diabetes self-management training.

0% coinsurance for Medicare-covered diabetes supplies and services.  
20% coinsurance for therapeutic shoes or inserts.

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### **Diagnostic tests lab and radiology services and x-rays (Costs for these services may be different if received in an outpatient surgery setting)**

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0-20% coinsurance for Medicare-covered diagnostic procedures/tests. 0% coinsurance for Medicare-covered lab services. 0-20% coinsurance for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). 20% coinsurance for other Medicare-covered therapeutic radiological services. 20% coinsurance for Medicare-covered x-rays.

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### **Renal dialysis**

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20% per visit

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### **Durable medical equipment (wheelchairs oxygen etc.)**

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20% per item

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### **Doctor's office visits**

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Primary Physician: 0% Coinsurance Specialist Physician: 0% Coinsurance

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### **Emergency care**

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20% per visit, waived if admitted within 2 hours. Maximum \$90 per visit.

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### **Foot care (podiatry services)**

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0% coinsurance for routine visits. 20% coinsurance for Medicare-covered visits. Max of 1 routine visits every three months.

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## Hearing services

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0% coinsurance for fitting/evaluation for hearing aid. 20% coinsurance for Medicare-covered benefits. \$0 copay for hearing aids (all types). Hearing aid max of 2 every year. Fitting max of 1 every year. \$0 copay for routine hearing exams. Routing hearing exam max of 1 every year. Max of 1250 benefit for this plan for hearing aids every year.

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## Home health care

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0% coinsurance

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## Hospice

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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.

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## Inpatient hospital care

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\$1200 copay for stay

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## Mental health care

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\$1200 copay for stay

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## Over-the-counter items

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\$0 copay for over-the-counter drugs. Max of \$255 benefit for this plan every three months. Not all medications of the OTC list in Chapter 4 of Medicare Managed Care Manual are included.

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## Outpatient prescription drugs

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20% coinsurance for chemo drugs.20% coinsurance for prescriptions.

#### **Tier 1 (Preferred Generic)**

<b>Pharmacy Type</b>	<b>30 day supply</b>	<b>60 day supply</b>	<b>90 day supply</b>
Preferred Retail:	Not Offered	Not Offered	Not Offered
Standard Retail:	\$0	\$0	\$0
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	\$0	\$0	\$0

#### **Tier 2 (Generic)**

<b>Pharmacy Type</b>	<b>30 day supply</b>	<b>60 day supply</b>	<b>90 day supply</b>
Preferred Retail:	Not Offered	Not Offered	Not Offered
Standard Retail:	\$0	\$0	\$0
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	\$0	\$0	\$0

#### **Tier 3 (Preferred Brand)**

<b>Pharmacy Type</b>	<b>30 day supply</b>	<b>60 day supply</b>	<b>90 day supply</b>
Preferred Retail:	Not Offered	Not Offered	Not Offered
Standard Retail:	\$47	\$94	\$141
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	\$47	\$94	\$141

#### **Tier 4 (Non-Preferred Drug)**

<b>Pharmacy Type</b>	<b>30 day supply</b>	<b>60 day supply</b>	<b>90 day supply</b>
Preferred Retail:	Not Offered	Not Offered	Not Offered
Standard Retail:	\$100	\$200	\$300
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	\$100	\$200	\$300

#### **Tier 5 (Specialty Tier)**

<b>Pharmacy Type</b>	<b>30 day supply</b>	<b>60 day supply</b>	<b>90 day supply</b>
Preferred Retail:	Not Offered	Not Offered	Not Offered
Standard Retail:	30%	Not Offered	Not Offered
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	30%	Not Offered	Not Offered

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#### **Outpatient rehabilitation**

20% coinsurance for Medicare-covered cardiac rehabilitation services.  
20% coinsurance for Medicare-covered intensive cardiac rehabilitation services. 20% coinsurance for Medicare-covered pulmonary rehabilitation services.

20% coinsurance for physical therapy and speech therapy. 20% coinsurance for occupational therapy.

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**Outpatient substance abuse**

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40% coinsurance for group visits.40% coinsurance for individual visits.

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**Outpatient surgery**

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0-20% per visit

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**Preventive care**

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Annual physical exam covered. 0% coinsurance for annual physical exam. Supplemental benefits available, see carrier site for more detailed information.

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**Prosthetic devices (braces artificial limbs etc.)**

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20% coinsurance for Medicare-covered medical supplies. 20% coinsurance for Medicare-covered prosthetic devices.

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**Skilled Nursing Facility (SNF)**

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\$0 copay for days 1-20 \$184 copay for days 21-100

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**Transportation**

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\$0 copay. Max of 40 trips to plan-approved locations every year. Covered modes of transportation include van, taxi to plan approved locations.

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**Urgently needed services**

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20% coinsurance. Maximum \$65 per visit.

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**Vision services**

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0% coinsurance for Medicare-covered eyewear. 20% coinsurance for Medicare-covered exams. \$0 copay for contacts. \$0 copay for frames. \$0 copay for glasses. \$0 copay for lenses. \$0 copay for routine eye exams. Routine eye exam max of 1 every year. \$0 copay for upgrades. Max of \$500 combined benefit for this plan every year.

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