MEDICARE ADVANTAGE / PDP

Plan Details

Aetna Medicare

$0.00

Plan: **Aetna Medicare Value (PPO)**

Max Out of Pocket: **$7,550**

Annual Drug Deductible: **$0.00**

ID: **H5521-263-0**

Star Rating: **4.0**

Plan Type: **Local PPO**

Part B Reduction: **No**

Effective Year: **2021**

City: **PHILADELPHIA**

State: **PA**

Zip: **19145**

Chiropractic care

Out of Network: 40% coinsurance.

In Network: Not covered. $20 copay for Medicare-covered visits.

Dental services

Out of Network: $0 copay. (Preventive Dental)

Out of Network: $0 copay. (Comprehensive Dental)

Out of Network: 40% coinsurance. (Comprehensive Dental)

In Network: $45 copay 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 $750 combined preventive and comprehensive dental benefits for this plan every year.

Diabetes supplies and services

Out of Network: 0-20% coinsurance.

In Network: $0 copay for diabetes self-management training.

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

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

Out of Network: 40% coinsurance. (Diagnostic Procedures/Tests)

Out of Network: 40% coinsurance. (Lab Services)

Out of Network: 40% coinsurance. (Diagnostic Radiological Services)

Out of Network: 40% coinsurance. (Therapeutic Radiological Services)

Out of Network: 40% coinsurance. (Outpatient X-Ray Services)

In Network: $0-20 copay for Medicare-covered diagnostic procedures/tests. $0-5 copay for Medicare-covered lab services. $0-295 copay for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). $60 copay for other Medicare-covered therapeutic radiological services. $30 copay for Medicare-covered x-rays.

Doctor's office visits

Out of Network: 40% coinsurance. (Primary Care Physician Services)

Out of Network: 40% coinsurance. (Physician Specialist Services)

In Network: Primary Physician: $10 copay Specialist Physician: $45 copay

Durable medical equipment (wheelchairs oxygen etc.)

Out of Network: 40% coinsurance.

In Network: 20% per item

Foot care (podiatry services)

Out of Network: 40% coinsurance.

In Network: $45 copay for routine visits. $45 copay for Medicare-covered visits. Max of 1 routine visits every three months.

Hearing services

Out of Network: 40% coinsurance. (Hearing Exams)

Out of Network: $0 copay. (Hearing Aids)

In Network: $0 copay for hearing aids (all types). Hearing aid max of 2 every year. $0 copay for fitting/evaluation for hearing aid. 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.

Home health care

Out of Network: $0 copay.

In Network: $0 copay

Mental health care

Out of Network: 45% coinsurance.

Out of Network: 40% coinsurance for stay

In Network: $1590 copay for stay

Outpatient rehabilitation

Out of Network: 40% coinsurance. (Cardiac Rehabilitation Services)

Out of Network: 40% coinsurance. (Intensive Cardiac Rehabilitation Services)

Out of Network: 40% coinsurance. (Pulmonary Rehabilitation Services)

Out of Network: 40% coinsurance. (Occupational Therapy Services)

Out of Network: 40% coinsurance. (Physical Therapy and Speech-Language Pathology Services)

In Network: $0 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services. $0 copay for Medicare-covered pulmonary rehabilitation services.

In Network: $40 copay for physical therapy and speech therapy. $40 copay for occupational therapy.

Outpatient substance abuse

Out of Network: 45% coinsurance.

In Network: $40 copay for group visits. $40 copay for individual visits

Outpatient surgery

Out of Network: 40% coinsurance. (Ambulatory Surgical Center (ASC) Services)

In Network: $0-350 per visit

Over-the-counter items

Out of Network: $0 copay. Plan benefit max of $60.

In Network: $0 copay for over-the-counter drugs. Max of $60 benefit for this plan every three months. Not all medications of the OTC list in Chapter 4 of Medicare Managed Care Manual are included.

Prosthetic devices (braces artificial limbs etc.)

Out of Network: 40% coinsurance.

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

Renal dialysis

Out of Network: 50% coinsurance.

In Network: 20% per visit

Vision services

Out of Network: 40% coinsurance. (Eye Exams)

Out of Network: 40% coinsurance. (Eyewear)

In Network: $0 copay for routine eye exams. Routine eye exam max of 1 every year. $0-45 copay for Medicare-covered eye exams. $0 copay for Medicare-covered eye wear.

Preventive care

Out of Network: 40% coinsurance.

In Network: Annual physical exam covered. $0 copay for annual physical exam. Supplemental benefits available, see carrier site for more detailed information.

Outpatient prescription drugs

Out of Network: 40% coinsurance.

In Network: 20% coinsurance for chemo drugs.20% coinsurance for prescriptions.

Tier 1 (Preferred Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$2	$4	$5
Standard Retail:	$15	$30	$45
Preferred Mail Order:	$2	$4	$5
Standard Mail Order:	$15	$30	$45

Tier 2 (Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$5	$10	$10
Standard Retail:	$20	$40	$60
Preferred Mail Order:	$5	$10	$10
Standard Mail Order:	$20	$40	$60

Tier 3 (Preferred Brand)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$47	$94	$141
Standard Retail:	$47	$94	$141
Preferred Mail Order:	$47	$94	$141
Standard Mail Order:	$47	$94	$141

Tier 4 (Non-Preferred Drug)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$100	$200	$300
Standard Retail:	$100	$200	$300
Preferred Mail Order:	$100	$200	$300
Standard Mail Order:	$100	$200	$300

Tier 5 (Specialty Tier)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	33%	Not Offered	Not Offered
Standard Retail:	33%	Not Offered	Not Offered
Preferred Mail Order:	33%	Not Offered	Not Offered
Standard Mail Order:	33%	Not Offered	Not Offered

Inpatient hospital care

Out of Network: 40% coinsurance for stay

In Network: $225 copay for days 1-7 $0 copay for days 8-90 Benefit continues for unlimited days of hospital stay.

Skilled Nursing Facility (SNF)
Out of Network: 40% coinsurance for stay In Network: $0 copay for days 1-20 $184 copay for days 21-100
Monthly premium deductible and limits on how much you pay for covered services
$ plan deductible. $11300 in and out-of-network out of pocket maximum. $7550 in-network out of pocket maximum.
Acupuncture
Not covered
Ambulance
$265 copay
Emergency care
$90 per visit, waived if admitted within 24 hours. Maximum $90 per visit.
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.
Transportation
Not covered
Urgently needed services
$10-50 copay. Maximum $65 per visit.