# Comparison of Benefits for the Medicare Advantage Prescription Drug Plans

## MA-PD PPO Plan

### All Benefits are Based on Medicare-Covered Services

| Services | Aetna Medicare |
| --- | --- |
| **Hospitalization**<br>Semiprivate room (private room if medically necessary)<br><br>Nursing services, medications and all meals<br><br>Laboratory tests, X-rays and other radiology services<br><br>Inpatient physician and surgical services, including anesthesia<br><br>Necessary medical supplies and appliances<br><br>Blood and its administration<br><br>Operating room, special care units and rehabilitation services | You pay $0 per stay after $150 plan deductible |
| **Organ Transplants**<br>Must be performed in a Medicare-approved transplant facility | You pay $0 per stay after $150 plan deductible |
| **Skilled Nursing Facility (Inpatient Services)**<br>Semi-private room, regular nursing services and all meals<br><br>Physical, occupational and speech therapy<br><br>Drugs and necessary medical equipment and supplies furnished by the facility<br><br>Blood and its administration<br><br>Inpatient radiology and pathology<br><br>Use of appliances such as wheelchairs | You pay $0 per stay after $150 plan deductible |

| Services | Aetna Medicare |
|---|---|
| **Outpatient Hospital Services**<br>Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility | You pay $0 after $150 plan deductible |
| **Urgent Care Services**<br>Urgently needed services worldwide | You pay $0 |
| **Emergency Services**<br>Emergency services needed worldwide | You pay $0 |
| **Ambulance Services**<br>When medically necessary | You pay $0 |
| **Professional Services**<br>Office visit<br><br>Consultation, diagnosis and treatment by a specialist<br><br>Medical and surgical care<br><br>Allergy tests and treatment (serum)<br><br>Diagnostic tests and treatment<br><br>Medical supplies including casts, dressings and splints | You pay $0 after $150 plan deductible |
| **Physical, Occupational and Speech Therapy Services** | You pay $0 after $150 plan deductible |
| **Laboratory Services** | You pay $0 after $150 plan deductible |
| **X-Ray/Diagnostic Radiology** | You pay $0 after $150 plan deductible |
| **Hearing Examinations** | You pay $0 |
| **Chiropractic**<br>Limited to manual manipulation of the spine as medically necessary | You pay $0 |

Plan changes are indicated by **bold text**.

| Services | Aetna Medicare |
| --- | --- |
| **Part-Time or Intermittent Skilled Nursing Care**<br>Home health aide in conjunction with skilled care<br><br>Physical, speech and occupational therapy<br><br>Medical supplies and equipment (excluding medications) provided by the agency | You pay $0 after $150 plan deductible |
| **Durable Medical Equipment**<br>Durable medical equipment (DME) and supplies<br><br>Prosthetic devices<br><br>Therapeutic shoes/inserts for severe diabetes | You pay $0 after $150 plan deductible |

Plan changes are indicated by **bold text**.
This is only a sample of services covered by the plan. For more information, contact each plan. Refer to Contact Information at the back of this guide.

## Medicare Preventive Services

Aetna Medicare covers many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100 percent when you use a doctor or other health care provider who is a Medicare eligible provider.

For Aetna Medicare to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services as governed by Medicare, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2019 *Medicare & You* handbook.

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | Aetna Medicare |
|---|---|
| This plan uses a formulary<br><br>Some drugs require prior authorization<br><br>Quantity limits apply to certain drugs<br><br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003<br><br>You will be notified before changes are made to your plan's formulary | **30-day supply**<br>Up to $9 copay – Tier 1<br>Up to $45 copay – Tier 2<br>Up to $75 copay – Tier 3<br>33% coinsurance – Tier 4<br>$0 copay smoking cessation drugs – Tier 5<br><br>**31- to 90-day supply**<br>Up to $9 copay – Tier 1<br>Up to $90 copay – Tier 2<br>Up to $150 copay – Tier 3<br>Specialty drugs are limited to a 30-day supply<br>$0 copay smoking cessation drugs – Tier 5<br><br>Once you reach the **$5,100** out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the year.<br><br>Retail and mail order are available for up to a 90-day supply. |

Plan changes are indicated by **bold text**.

# MA-PD HMO Plans

## All Benefits are Based on Medicare-Covered Services

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **Hospitalization**<br>Semiprivate room (private room if medically necessary)<br><br>Nursing services and medications<br><br>Laboratory tests, X-rays and other radiology services<br><br>Inpatient physician and surgical services, including anesthesia<br><br>Necessary medical supplies and appliances<br><br>Blood and its administration<br><br>Operating room, special care units and rehabilitation services | $50 copay each day for days 1-5<br>$0 copay each day for days 6-90 for a Medicare-covered stay in a network hospital<br>Prior authorization required, except in an emergency<br><br>You are covered for unlimited days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. You must pay the inpatient hospital copay for each benefit period. | $250 copay per admission<br>You are covered for unlimited days each benefit period.<br>Prior authorization required, except in an emergency. |
| **Organ Transplants**<br>Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas and stem cell<br>Must be performed in a Medicare-approved transplant facility | $50 copay each day for days 1-5<br>$0 copay each day for days 6-90 | $250 copay per admission<br>You are covered for unlimited days each benefit period.<br>Prior authorization required except in the case of an emergency. |
| **Outpatient Hospital Services**<br>Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility.<br><br>Radiation therapy<br><br>Blood | $0 copay for each visit<br>Prior authorization required<br><br>$0 copay<br><br>$0 copay | $0 copay per surgery in an ambulatory surgery center<br>$200 copay per surgery in an outpatient hospital<br><br>$40 copay<br><br>$0 copay |

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **In-Area Urgent Care Services** | **$10** copay for each visit | $20 copay for each visit |
| **Out-of-Area Urgent Care Services**<br>During a temporary absence from service area | **$10** copay for each visit worldwide | $20 copay for each visit nationwide |
| **Emergency Services** | **$120** copay for each Medicare-covered visit worldwide<br>Waived if admitted inpatient to hospital within 48 hours for same condition | $75 copay for each visit nationwide; all-inclusive<br>Waived if admitted inpatient to hospital or for outpatient surgery within 24 hours for same condition |
| **Ambulance Services**<br>Medically necessary services as covered by Medicare | $50 copay<br>Waived if admitted inpatient to hospital | $50 copay<br>Waived if admitted inpatient to hospital |
| **Skilled Nursing Facility (Inpatient Services)**<br>Semi-private room and regular nursing services<br><br>Physical, occupational and speech therapy<br><br>Drugs and necessary medical equipment and supplies furnished by facility<br><br>Blood and its administration<br><br>Inpatient radiology and pathology<br><br>Use of appliances such as wheelchairs | $0 copay for days 1-20<br>$50 copay for days 21-100 for each benefit period<br>No prior hospital stay required<br>Prior authorization required<br><br>All services listed at left are inclusively covered under the skilled nursing facility copayment. | $0 copay per day for days 1-20<br>$160 copay per day for days 21-100<br>No prior hospital stay required<br>Prior authorization required<br><br>All services listed at left are inclusively covered under the skilled nursing facility copayment. |

Plan changes are indicated by **bold text**.

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **Professional Services**<br>Office visit<br><br>Consultation, diagnosis and treatment by a specialist<br><br>Medical and surgical care<br><br>Allergy tests and treatment (serum)<br><br>Diagnostic tests and treatment<br><br>Medical supplies including casts, dressings and splints | **$0** copay for each PCP visit<br><br>**$10** copay for each specialist visit | $0 copay for each PCP visit<br><br>$20 copay for each specialist visit<br>Prior authorization required, except for OB/GYN |
| **X-Ray/Diagnostic Radiology Services** | $0 copay | $0 copay |
| **Laboratory Services** | $0 copay for each diagnostic procedure and test<br>Prior authorization may apply. | $0 copay |
| **Physical, Occupational and Speech Therapy Services** | **$0** copay for each visit<br>Prior authorization required | $20 copay for each visit<br>Prior authorization required |
| **Hearing Examinations** | **$0** copay for routine hearing tests<br>**$0** copay for diagnostic hearing exams<br>You pay 100% for hearing aids | $0 copay for each PCP diagnostic evaluation<br>$20 copay for each specialist exam to diagnose and treat hearing and balance issues |
| **Chiropractic**<br>Limited to manual manipulation of the spine as medically necessary | **$10** copay each visit<br>Prior authorization required | $20 copay each visit<br>No prior authorization required |

Plan changes are indicated by **bold text**.

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **Part-Time or Intermittent Skilled Nursing Care**<br>Home health aide in conjunction with skilled care<br><br>Physical, speech and occupational therapy<br><br>Medical supplies and equipment (excluding medications) provided by the agency | **$0** copay for Medicare-covered home health visits<br>Prior authorization required | $0 copay for home health visits<br>Prior authorization required |
| **Durable Medical Equipment**<br>Durable medical equipment and supplies | $0 to $50 copay or 20% coinsurance for each item<br>Prior authorization required | 20% coinsurance for each item<br>Prior authorization required |
| Prosthetic devices | $0 copay for each device<br>Prior authorization required | $0 if surgically implanted<br>20% coinsurance per external device<br>Prior authorization required |
| Therapeutic shoes/inserts for severe diabetes | $0 copay for each orthotic<br>Prior authorization required | $0 for each orthotic<br>Prior authorization required |

Plan changes are indicated by **bold text**.
This is only a sample of services covered by each plan. For more information, contact each plan. Refer to Contact Information at the back of this guide.

## Medicare Preventive Services

The MA-PD HMO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100 percent when you use a network provider.

For your plan to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of these preventive services as governed by Medicare, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2019 *Medicare & You* handbook.

# Pharmacy Copay Structure for Part D Network Benefits

<table>
<tr><th>General Information</th><th>CommunityCare<br>Senior Health Plan</th></tr>
<tr><td>This plan uses a formulary<br><br>Some drugs require prior authorization<br><br>Quantity limits apply to certain drugs<br><br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003.<br><br>You will be notified before changes are made to your plan's formulary.</td><td>30-day supply<br>$0 copay – Tier 1 preferred generic drugs<br>Up to $10 copay – Tier 2 generic drugs<br>Up to $30 copay – Tier 3 preferred brand drugs<br>Up to $60 copay – Tier 4 non-preferred drugs (including tobacco cessation)<br>33% coinsurance – Tier 5 specialty drugs and certain injectables<br><br>90-day supply<br>$0 copay – Tier 1 preferred generic drugs<br>Up to $20 copay – Tier 2 generic drugs<br>Up to $60 copay – Tier 3 preferred brand drugs<br>Up to $120 copay – Tier 4 non-preferred drugs (including tobacco cessation)<br>33% coinsurance – Tier 5 specialty drugs and certain injectables<br><br>Mail order is available for up to a 90-day supply.<br><br>Once you reach the $5,100 out-of-pocket maximum, you pay the greater of 5% of the cost or $3.40 for generic drugs and preferred multi-source brand drugs or $8.50 for all other drugs for the remainder of the calendar year.</td></tr>
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Plan changes are indicated by **bold text**.

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | Generations by GlobalHealth | |
|---|---|---|
| Mandatory generic and brand formulary medications you get at a network pharmacy<br><br>Some drugs require prior authorization<br><br>Quantity limits apply to certain drugs<br><br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003.<br><br>You will be notified before changes are made to your plan's formulary. | **Preferred Retail**<br>**30-day supply**<br>$5 copay – Tier 1<br>$15 copay – Tier 2<br>$42 copay – Tier 3<br>40% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**$5 copay – Tier 6**<br><br>**31- to 90-day supply**<br>$15 copay – Tier 1<br>$45 copay – Tier 2<br>$126 copay – Tier 3<br>40% coinsurance – Tier 4<br>Not covered – Tier 5<br>**$0 copay – Tier 6** | **Standard Retail**<br>**30-day supply**<br>$10 copay – Tier 1<br>$20 copay – Tier 2<br>$47 copay – Tier 3<br>50% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**$10 copay – Tier 6**<br><br>**31- to 90-day supply**<br>$30 copay – Tier 1<br>$60 copay – Tier 2<br>$141 copay – Tier 3<br>50% coinsurance – Tier 4<br>Not covered – Tier 5<br>**$30 copay – Tier 6** |
| | **Preferred Mail Order**<br>**30-day supply**<br>$5 copay – Tier 1<br>$15 copay – Tier 2<br>$42 copay – Tier 3<br>**40%** coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**$5 copay – Tier 6**<br><br>**31- to 90-day supply**<br>**$15** copay – Tier 1<br>**$45** copay – Tier 2<br>**$126** copay – Tier 3<br>**40%** coinsurance – Tier 4<br>Not covered – Tier 5<br>**$0 copay – Tier 6** | **Standard Mail Order**<br>**30-day supply**<br>$10 copay – Tier 1<br>$20 copay – Tier 2<br>$47 copay – Tier 3<br>50% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**$10 copay – Tier 6**<br><br>**31- to 90-day supply**<br>$30 copay – Tier 1<br>$60 copay – Tier 2<br>$141 copay – Tier 3<br>50% coinsurance – Tier 4<br>Not covered – Tier 5<br>**$30 copay – Tier 6** |
| | Once you reach the **$5,100** out-of-pocket maximum, you pay Medicare-defined amounts for covered generic and brand prescription drugs purchased at network pharmacies for the remainder of the year.<br><br>Gap coverage for Tiers 1 and 6, and insulin and syringes in Tier 3. | |

Plan changes are indicated by **bold text**.