

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

Services	Aetna Medicare
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	You pay \$0 after \$150 plan deductible
Urgent Care Services Urgently needed services worldwide	You pay \$0
Emergency Services Emergency services needed worldwide	You pay \$0
Ambulance Services When medically necessary	You pay \$0
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment 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 Limited to manual manipulation of the spine as medically necessary	You pay \$0

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

Services	Aetna Medicare
<p>Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care</p> <p>Physical, speech and occupational therapy</p> <p>Medical supplies and equipment (excluding medications) provided by the agency</p>	You pay \$0 after \$150 plan deductible
<p>Durable Medical Equipment Durable medical equipment (DME) and supplies</p> <p>Prosthetic devices</p> <p>Therapeutic shoes/inserts for severe diabetes</p>	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 www.cms.gov or www.medicare.gov. You can also refer to the 2018 *Medicare & You* handbook.

Pharmacy Copay Structure for Part D Network Benefits

General Information	Aetna Medicare
<p>Mandatory generic and brand formulary medications you get at a network pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the <i>Medicare Modernization Act</i> of 2003</p> <p>You will be notified before changes are made to your plan's formulary</p>	<p>30-Day Supply Up to \$9 copay – Tier 1 Up to \$45 copay – Tier 2 Up to \$75 copay – Tier 3 33% coinsurance – Tier 4 \$0 copay smoking cessation drugs on any tier</p> <p>31- to 90-day supply Up to \$9 copay – Tier 1 Up to \$90 copay – Tier 2 Up to \$150 copay – Tier 3 Specialty drugs are limited to a 30-day supply \$0 copay smoking cessation drugs on any tier</p> <p>Once you reach the \$5,000 out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the year.</p> <p>Retail and mail order are available for up to a 90-day supply.</p>

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
<p>Hospitalization Semiprivate room (private room if medically necessary)</p> <p>Nursing services and medications</p> <p>Laboratory tests, X-rays and other radiology services</p> <p>Inpatient physician and surgical services, including anesthesia</p> <p>Necessary medical supplies and appliances</p> <p>Blood and its administration</p> <p>Operating room, special care units and rehabilitation services</p>	<p>\$50 copay each day for days 1-5 \$0 copay each day for days 6-90 for a Medicare-covered stay in a network hospital Prior authorization required, except in an emergency</p> <p>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.</p>	<p>\$250 copay per admission You are covered for unlimited days each benefit period. Prior authorization required, except in an emergency.</p>
<p>Organ Transplants Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas and stem cell Must be performed in a Medicare-approved transplant facility</p>	<p>\$50 copay each day for days 1-5 \$0 copay each day for days 6-90</p>	<p>\$250 copay per admission You are covered for unlimited days each benefit period. Prior authorization required except in the case of an emergency.</p>
<p>Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility.</p> <p>Radiation therapy</p> <p>Blood</p>	<p>\$0 copay for each visit Prior authorization required</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$0 copay per surgery in an ambulatory surgery center or preferred outpatient hospital \$200 copay per surgery in a non-preferred outpatient hospital \$40 copay</p> <p>\$0 per pint, 3 pint deductible waived</p>

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

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
In-Area Urgent Care Services	\$20 copay for each visit	\$20 copay for each visit
Out-of-Area Urgent Care Services During a temporary absence from service area	\$20 copay for each visit worldwide	\$20 copay for each visit nationwide
Emergency Services	\$75 copay for each Medicare-covered visit worldwide Waived if admitted inpatient to hospital within 48 hours for same condition	\$75 copay for each visit nationwide; all-inclusive Waived if admitted inpatient to hospital or for outpatient surgery within 24 hours for same condition
Ambulance Services Medically necessary services as covered by Medicare	\$50 copay Waived if admitted inpatient to hospital	\$50 copay Waived if admitted inpatient to hospital
Skilled Nursing Facility (Inpatient Services) Semi-private room and regular nursing services Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	\$0 copay for days 1-20 \$50 copay for days 21-100 for each benefit period No prior hospital stay required Prior authorization required All services listed at left are inclusively covered under the skilled nursing facility copayment.	\$0 copay per day for days 1-20 \$160 copay per day for days 21-100 No prior hospital stay required Prior authorization required 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 Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	\$10 copay for each PCP visit \$20 copay for each specialist visit	\$0 copay for each PCP visit \$20 copay for each specialist visit 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. Prior authorization may apply.	\$0 copay
Physical, Occupational and Speech Therapy Services	\$40 copay for each visit Prior authorization required	\$20 copay for each visit Prior authorization required
Hearing Examinations	\$10 copay for routine hearing tests \$20 copay for diagnostic hearing exams You pay 100% for hearing aids	\$0 copay for each PCP diagnostic evaluation \$20 copay for each specialist exam to diagnose and treat hearing and balance issues
Chiropractic Limited to manual manipulation of the spine as medically necessary	\$15 copay each visit Prior authorization required	\$20 copay each visit

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

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
<p>Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care</p> <p>Physical, speech and occupational therapy</p> <p>Medical supplies and equipment (excluding medications) provided by the agency</p>	<p>\$35 copay for Medicare-covered home health visits Prior authorization required</p>	<p>\$0 copay for home health visits Prior authorization required</p>
<p>Durable Medical Equipment Durable medical equipment and supplies</p> <p>Prosthetic devices</p> <p>Therapeutic shoes/inserts for severe diabetes</p>	<p>\$0 to \$50 copay or 20% coinsurance for each item Prior authorization required</p> <p>\$0 copay for each device Prior authorization required</p> <p>\$0 copay for each orthotic Prior authorization required</p>	<p>20% coinsurance for each item Prior authorization required</p> <p>\$0 if surgically implanted 20% coinsurance per external device Prior authorization required</p> <p>\$0 for each orthotic Prior authorization required</p>

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 www.cms.gov or www.medicare.gov. You can also refer to the 2018 *Medicare & You* handbook.

Pharmacy Copay Structure for Part D Network Benefits

General Information	CommunityCare Senior Health Plan
<p>Mandatory generic and brand formulary medications you get at a network pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the <i>Medicare Modernization Act</i> of 2003.</p> <p>You will be notified before changes are made to your plan's formulary.</p>	<p>30-day supply</p> <p>\$0 copay – Tier 1 preferred generic drugs Up to \$10 copay – Tier 2 generic drugs Up to \$30 copay – Tier 3 preferred brand drugs Up to \$60 copay – Tier 4 non-preferred drugs (including tobacco cessation) 33% coinsurance for specialty drugs and certain injectables</p> <p>90-day supply</p> <p>\$0 copay – Tier 1 preferred generic drugs Up to \$20 copay – Tier 2 generic drugs Up to \$60 copay – Tier 3 preferred brand drugs Up to \$120 copay – Tier 4 non-preferred drugs (including tobacco cessation) 33% coinsurance for specialty drugs and certain injectables</p> <p>Mail order is available for up to a 90-day supply.</p> <p>Once you reach the \$5,000 out-of-pocket maximum, you pay the greater of 5% of the cost or \$3.35 for generic drugs and preferred multi-source brand drugs or \$8.35 for all other drugs for the remainder of the calendar year.</p>

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

Pharmacy Copay Structure for Part D Network Benefits

General Information	Generations by GlobalHealth	
<p>Mandatory generic and brand formulary medications you get at a network pharmacy</p> <p>Some drugs require prior authorization</p> <p>Quantity limits apply to certain drugs</p> <p>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the <i>Medicare Modernization Act</i> of 2003.</p> <p>You will be notified before changes are made to your plan's formulary.</p>	<p>Preferred Retail 30-day supply \$5 copay – Tier 1 \$15 copay – Tier 2 \$42 copay – Tier 3 40% coinsurance – Tier 4 33% coinsurance – Tier 5</p> <p>31- to 90-day supply \$15 copay – Tier 1 \$45 copay – Tier 2 \$126 copay – Tier 3 40% coinsurance – Tier 4</p> <p>Preferred Mail Order 30-day supply \$5 copay – Tier 1 \$15 copay – Tier 2 \$42 copay – Tier 3 30% coinsurance – Tier 4 33% coinsurance – Tier 5</p> <p>31- to 90-day supply \$10 copay – Tier 1 \$30 copay – Tier 2 \$84 copay – Tier 3 30% coinsurance – Tier 4</p>	<p>Standard Retail 30-day supply \$10 copay – Tier 1 \$20 copay – Tier 2 \$47 copay – Tier 3 50% coinsurance – Tier 4 33% coinsurance – Tier 5</p> <p>31- to 90-day supply \$30 copay – Tier 1 \$60 copay – Tier 2 \$141 copay – Tier 3 50% coinsurance – Tier 4</p> <p>Standard Mail Order 30-day supply \$10 copay – Tier 1 \$20 copay – Tier 2 \$47 copay – Tier 3 50% coinsurance – Tier 4 33% coinsurance – Tier 5</p> <p>31- to 90-day supply \$30 copay – Tier 1 \$60 copay – Tier 2 \$141 copay – Tier 3 50% coinsurance – Tier 4</p>
	<p>Once you reach the \$5,000 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.</p> <p>Gap coverage for Tiers 1 and 2 and insulin and syringes in Tier 3.</p>	

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