



Benefits and Premiums are effective January 1, 2021 through December 31, 2021

## SUMMARY OF BENEFITS PROVIDED BY AETNA HEALTH PLANS INC.

PLAN FEATURES	This is what you pay for network providers
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Maximum Out-of-Pocket	\$2,500

#### **Amount**

Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except hearing aid reimbursement, vision reimbursement and Medicare prescription drug coverage that may be available on your plan.

HOSPITAL CARE	This is what you pay for network providers	
Inpatient Hospital Care	\$0 per stay	
The member cost sharing applies to covered benefits incurred during a member's inpatient		
stay.		

Prior authorization or physician's order may be required.

Outpatient Hospital Care	\$0	
Prior authorization or physician's order may be required.		
PHYSICIAN SERVICES	This is what you pay for network providers	
Primary Care Physician Visits	\$15	
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	\$25	

Primary Care Physician Selection	Recommended
Referral Requirement	No referral needed when accessing network providers.
PREVENTIVE CARE	This is what you pay for network providers
Annual Wellness Exams	\$0



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Aetna Medicare <sup>SM</sup> Plan (HMO)
Open Access HMO1525 SEHBP Plan

One exam every 12 months.		
Routine Physical Exams	\$0	
One exam every 12 months.		
<b>Medicare Covered Immunizations</b>	\$0	
Pneumococcal, Flu, Hepatitis B		
Routine GYN Care (Cervical and	\$0	
Vaginal Cancer Screenings)		
One routine GYN visit and pap smea	r every 24 months.	
Routine Mammograms (Breast	\$0	
Cancer Screening)		
<u>.</u>		
One baseline mammogram for mem	bers age 35-39; and one annual mammogram for	
members age 40 & over.		
Routine Prostate Cancer Screening	\$0	
Exam		
For covered males age 50 & over, every 12 months.		
Routine Colorectal Cancer	\$0	
Screening		
For all members age 50 & over.		
Routine Bone Mass Measurement	\$0	
	•	
Medicare Diabetes Prevention	\$0	
Program (MDPP)		
<u> </u>		

12 months of core session for program eligible members with an indication of pre-diabetes.

### Additional Medicare Preventive \$0

### Services

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use





- Screening and behavioral counseling for alcohol misuse
- · Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

EMERGENCY AND URGENT	This is what you pay for network providers
MEDICAL CARE	
<b>Emergency Care; Worldwide</b>	\$65
(waived if admitted)	

**Urgently Needed Care; Worldwide** \$25

DIAGNOSTIC PROCEDURES	This is what you pay for network providers
Outpatient Diagnostic Laboratory	\$0

Prior authorization or physician's order may be required.

Outpatient Diagnostic X-ray	\$0	
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Prior authorization or physician's order may be required.

Outpatient Diagnostic Testing \$0

Prior authorization or physician's order may be required.

Outpatient Complex Imaging \$0

Prior authorization or physician's order may be required.

HEARING SERVICES	This is what you pay for network providers
Routine Hearing Screening	\$0
One exam every 12 months	

DENTAL SERVICES This is what you pay for network providers

Medicare Covered Dental \$25 Non-routine care covered by Medicare.

Prior authorization or physician's order may be required.

VISION SERVICES	This is what you pay for network providers
Routine Eye Exams	\$0
One annual exam every 12 months.	



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**Diabetic Eye Exams** \$0

MENTAL HEALTH SERVICES This is what you pay for network providers

**Inpatient Mental Health Care** \$0 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Prior authorization or physician's order may be required.

**Outpatient Mental Health Care** \$25

Prior authorization or physician's order may be required.

**Inpatient Substance Abuse** \$0 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Prior authorization or physician's order may be required.

Outpatient Substance Abuse \$25

Prior authorization or physician's order may be required.

SKILLED NURSING SERVICES This is what you pay for network providers

Skilled Nursing Facility (SNF) Care \$0 copay per day, day(s) 1-120

Limited to 120 days per Medicare Benefit Period\*.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Prior authorization or physician's order may be required.

\*A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES	This is what you pay for network providers
<b>Outpatient Rehabilitation Services</b>	\$25

(Speech, Physical, and Occupational therapy)

Prior authorization or physician's order may be required.



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AMBULANCE SERVICES	This is what you pay for network providers	
Ambulance Services	\$0	
Prior authorization or physician's ord	der may be required.	
MEDICARE PART B DRUGS	This is what you pay for network providers	
Medicare Part B Prescription Drugs	\$0	
ADDITIONAL SERVICES	This is what you pay for network providers	
Blood	All components of blood are covered beginning with	
Covered in and out of network	the first pint.	
Observation Care	Your cost share for Observation Care is based upon	
Covered in and out of network	the services you receive.	
Outpatient Surgery	\$0	
Prior authorization or physician's order may be required.		
Home Health Agency Care	\$0	
Prior authorization or physician's ord	der may be required.	
Hospice Care	Covered by Original Medicare at a Medicare certified	
	hospice.	
Cardiac Rehabilitation Services	\$25	
Pulmonary Rehabilitation Services	\$25	
Radiation Therapy	\$25	
<b>Chiropractic Services</b>	\$15	
Limited to Original Medicare - cover	ed services for manipulation of the spine.	
Prior authorization or physician's order may be required.		
Durable Medical Equipment/	\$0	
Prosthetic Devices		
Prior authorization or physician's ord	· · ·	
Podiatry Services	\$25	
Limited to Original Medicare covered	d benefits only.	
Diabetic Supplies	\$0	
Includes supplies to monitor your blood glucose.		



# STATE OF NEW JERSEY Aetna Medicare <sup>SM</sup> Plan (HMO) Open Access HMO1525 SEHBP Plan

Outpatient Dialysis Treatments \$0

Prior authorization or physician's order may be required.

ADDITIONAL NON-MEDICARE	This is what you pay for Network Providers	
COVERED SERVICES		
Healthy Lifestyle Coaching	Covered	
One phone call per week.		
Resources For Living®	Covered	
For help locating resources for ev	ery day needs.	
Telehealth	Covered	

Telemedicine Services. Telehealth services covered when provided by PCP, Behavioral Health or Urgent Care providers. Member cost share will apply based on services rendered.

Wigs	\$500 once every 24 months
<b>Compression Stockings</b>	\$0
Non-Medicare Covered Foot	\$0
Orthotics	
Private Duty Nursing	\$0

Prior authorization or physician's order may be required.

For more information about Aetna plans, go to **www.aetna.com** or call Member Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

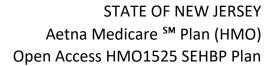
### **Medical Disclaimers**

### Not all HMO Plans are available in all areas

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other 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.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.





The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services not performed by your Aetna Medicare network doctor, except in an emergency or urgent situation
- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

### **Plan Disclaimers**

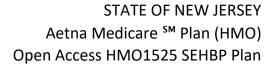
Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

To join the Aetna Medicare Advantage Plan (HMO), you must meet the requirements of the plan sponsor/your former employer, be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.





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.

You can read the Medicare & You 2021 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese:

注意:如果您使用中文,您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

This document is not intended to be member-facing as it does not include the required disclosures.

\*\*\*This is the end of this plan benefit summary\*\*\*

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