



2024 Summary of Benefits

Aetna Medicare Dual Preferred (PPO D-SNP)
H5522 - 024



Here's a summary of the services we cover from January 1, 2024 through December 31, 2024. Keep in mind: This is just a summary. Need a complete list of what we cover and any limitations? Just visit [AetnaMedicare.com/H5522-024](https://www.aetna.com/H5522-024) where you'll find the plan's *Evidence of Coverage (EOC)*. You may call us to request a copy.

We're here to help

You may have questions as you read through this information. And that's OK — we're here to help.

Not a member yet?

Call 1-833-859-6031 (TTY: 711)

October 1–March 31: 8 AM to 8 PM, 7 days a week

April 1–September 30: 8 AM to 8 PM,
Monday–Friday

An Aetna® team member will answer your call.

Already a member?

Call 1-866-409-1221 (TTY: 711)

8 AM to 8 PM, 7 days a week

An Aetna team member will answer your call.

Are you eligible to enroll?

To join Aetna Medicare Dual Preferred (PPO D-SNP), you must:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:
Pennsylvania: Blair, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Schuylkill, Snyder, Union
- Be in a Medicare Savings Program (MSP) or qualify for State Medicaid benefits. See table below for additional MSP details.

Better health is a team effort

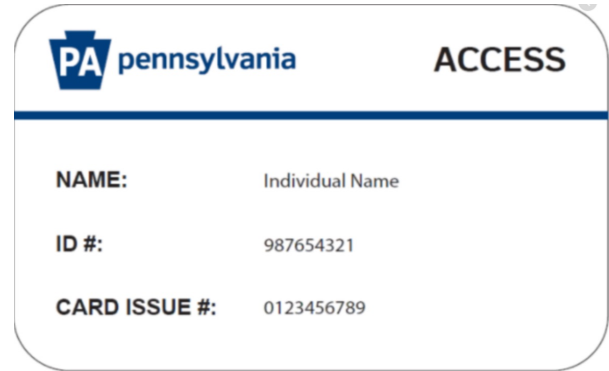
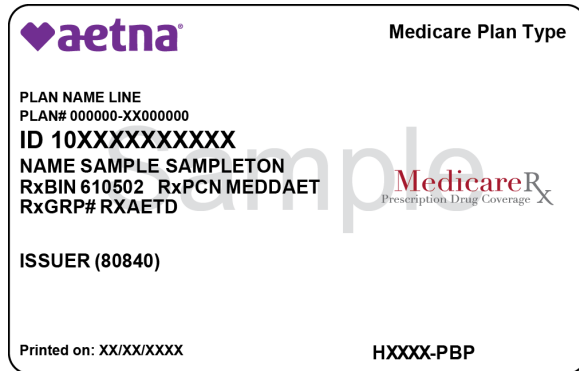
With our Medicare Advantage Dual Eligible Special Needs Plan, or D-SNP, you'll have a care team in your corner, ready to help you reach your best health and make life easier.

- Your **nurse care manager** is a single point of contact to help coordinate your care.
- Your **social worker** will link you to programs in your community and help with questions you have about social services.
- Your **care coordinator** will help schedule doctor appointments, arrange rides and work with you to meet your personal needs.
- Your **member advocate** will assist you in accessing State Medicaid benefits.

| Medicare Savings Program | What it covers |
|--|--|
| Qualified Medicare Beneficiary (QMB) | Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).) |
| Qualified Medicare Beneficiary Plus (QMB Plus) | Helps pay Medicare Part A and B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). You are also eligible for full Medicaid benefits from your state Medicaid program. |
| Specified Low-Income Medicare Beneficiary Plus (SLMB Plus) | Medicaid may cover some of your Medicare premiums and cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid. |
| Full Benefit Dual Eligible (FBDE) | Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid. |

If you are a Qualified Medicare Beneficiary (QMB) then your deductible, coinsurance, and/or copayment will be \$0 for services covered under Medicare Part A and B. All other categories, your deductible, coinsurance and/or copayment may be less for services that are covered under Medicare Part A and B.

Be sure to show your Aetna® member ID card **AND** your state Medicaid ID card when you visit the doctor or pharmacy.



What you should know

- **Plan type:** Aetna Medicare Dual Preferred (PPO D-SNP) is a D-SNP plan. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care.
- **D-SNP information:** Our D-SNP is for people on Medicare who are also eligible for some level of Medicaid assistance. It replaces your Original Medicare coverage. You'll still have Medicare, but you'll get it through us, instead of the federal government. We cover everything that Original Medicare covers and we provide additional benefits and services too.
- **Primary Care Physician (PCP):** A PCP is important to help coordinate your care. We require you to select a PCP. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Dual Preferred (PPO D-SNP) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Contact information:** To get more information about some benefits, please see the Contact quick reference chart at the end of this document.
- **Provider directory:** View your provider directory at [AetnaMedicare.com/H5522-024](https://www.aetna.com/H5522-024).

Plan premium, deductible, and maximum out-of-pocket (MOOP)



| Out-of-pocket costs | |
|---------------------|---|
| Monthly premium | \$0 |
| Plan deductible | <p>\$0 - \$226</p> <p>The annual plan deductible applies to certain out-of-network services.</p> <p>Your deductible is what you'll pay before we begin to pay for services. This is the 2023 amount and may change for 2024. Our plan will provide an updated amount as soon as it is released.</p> |
| MOOP | <p>\$8,850 for in-network services</p> <p>\$13,300 for in- and out-of-network services combined</p> <p>Depending on your Medicaid "Medicare Savings Program" eligibility category, Medicaid may pay your cost shares until you reach the Maximum Out of Pocket. Once you reach the limit, we will pay the full cost for plan covered services for the rest of the year.</p> |

Medical and hospital benefits



Hospital coverage

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|--|-----------------------|---|
| Inpatient | \$0 | 40% per stay after your plan deductible |
| Outpatient hospital observation services | \$0 | 40% per stay after your plan deductible |
| Outpatient hospital | \$0 | 40% after your plan deductible |
| Ambulatory surgical center | \$0 | 40% after your plan deductible |



Doctor visits

| Benefit | Your in-network costs | Your out-of-network costs |
|------------|-----------------------|--------------------------------|
| PCP | \$0 | 40% after your plan deductible |
| Specialist | \$0 | 40% after your plan deductible |



Preventive, emergency and urgent care

| Benefit | Your in-network costs | Your out-of-network costs |
|---|---|---------------------------|
| Preventive care | \$0 | \$0 |
| | For a full list of preventive services available, see the EOC. | |
| Emergency and urgent care (inside the U.S.) | \$0 | \$0 |
| Emergency and urgent care, including ambulance (outside the U.S.) | \$0 | \$0 |
| Emergency allowance (outside the U.S.) | Maximum coverage: \$50,000 (the most we'll pay for your worldwide emergency and urgent care combined) | |



Diagnostic services, labs, imaging

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|--|-----------------------|--------------------------------|
| Diagnostic tests and procedures | \$0 | 40% after your plan deductible |
| Lab services | \$0 | 40% after your plan deductible |
| Diagnostic radiology services, such as MRI | \$0 | 40% after your plan deductible |
| Outpatient x-rays | \$0 | 40% after your plan deductible |



Hearing services

| Benefit | Your in-network costs | Your out-of-network costs |
|-------------------------|---|--------------------------------|
| Diagnostic hearing exam | \$0 | 20% after your plan deductible |
| Routine hearing exam | <p>\$0</p> <p>You get one routine hearing exam every year. You can visit a provider in the NationsHearing network, or an out-of-network provider.</p> | \$0 |
| Hearing aids | <p>You get an annual benefit amount (allowance) up to a maximum amount of \$1,250 per ear, every year. This benefit amount can only be used to purchase hearing aids through a NationsHearing network provider. If the cost is over the benefit amount, you pay the difference.</p> | Not Covered |



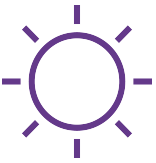
Dental services

| Benefit | Your in-network costs | Your out-of-network costs |
|-----------------|--|---|
| Dental services | <p>\$0 for preventive services including oral exams, bitewing x-rays and cleanings</p> <p>\$0 for comprehensive services including things like fillings, extractions, crowns, root canals, dentures, and implants</p> <p>\$5,000 annual benefit amount (allowance). This is the total amount that will be paid for covered preventive and comprehensive services combined. You are responsible for any costs over this amount. This benefit uses the Aetna Dental PPO Network, which is different from your medical network. You can use a provider in or out of the Aetna Dental PPO Network. However, in-network providers agree to bill us directly so you won't have to pay the provider and then submit a reimbursement request - and you may save money. To find a provider and learn more about this benefit visit AetnaMedicare.com/H5522-024</p> | <p>\$0 for preventive services including oral exams, bitewing x-rays and cleanings</p> <p>\$0 for comprehensive services including things like fillings, extractions, crowns, root canals, dentures, and implants</p> |



Vision services

| Benefit | Your in-network costs | Your out-of-network costs |
|---|---|--------------------------------|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 | 20% after your plan deductible |
| Glaucoma screening | \$0 | 20% after your plan deductible |
| Routine eye exam | \$0 | \$0 |
| | Our plan covers one exam every year. | |
| Contacts and eyeglasses | You get a vision eyewear benefit amount (allowance) up to \$500 every year for covered prescription eyewear. This benefit amount is administered through EyeMed. You can choose to use a provider outside of the EyeMed network, but you may be responsible for additional costs. Your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll need to pay the difference. | |



Mental health services

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|-------------------------------------|-----------------------|---|
| Inpatient psychiatric hospital stay | \$0 | 40% per stay after your plan deductible |
| Outpatient mental health therapy | \$0 | 40% after your plan deductible |
| Outpatient psychiatric therapy | \$0 | 40% after your plan deductible |



Skilled nursing facility (SNF) and therapy

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification. Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

| Benefit | Your in-network costs | Your out-of-network costs |
|-----------------------------|--|---|
| SNF care | \$0 | 40% per stay after your plan deductible |
| | Our plan covers up to 100 days per benefit period. | |
| Physical and speech therapy | \$0 | 40% after your plan deductible |
| Occupational therapy | \$0 | 40% after your plan deductible |



Ambulance and routine transportation

Your doctor often needs approval from us before we cover non-emergency air ambulance. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|---|---|--------------------------------|
| Ambulance (ground or air, one-way trip) | \$0 | 20% after your plan deductible |
| Routine, non-emergency transportation | \$0 | \$0 |
| | <p>You get up to 30 one-way rides each year to and from plan approved locations (up to 80 miles each ride). This benefit is administered through Access2Care. Please call Access2Care at least two business days in advance to schedule a ride. Tip: Be sure to schedule a ride both to and from your destination. This will count as two one-way rides.</p> <p>Important:</p> <ol style="list-style-type: none"> 1. When scheduling the ride, let the representative know if you will require assistance getting to and from the vehicle. They can confirm if you will need to have an escort (family member or caregiver) ride with you. 2. Please be ready when the driver arrives. | |



Medicare Part B drugs

Medicare Part B only covers certain medicines for certain conditions. These medicines are often given to you in your doctor’s office. They can include things like vaccines, injections, and nebulizers, among others. They can also include medicines you take at home using special medical equipment. Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|--------------------|-----------------------|--------------------------------|
| Chemotherapy drugs | \$0 | 40% after your plan deductible |
| Other Part B drugs | \$0 | 40% after your plan deductible |

Medicare Part D drugs



Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes.

| Benefit | Your costs in our plan |
|-----------------------|--|
| Deductible | \$0 |
| Initial Coverage | \$0 for all covered Part D drugs You can get a 30, 60 or 100-day supply of drugs. This includes home infusion drugs obtained through your Part D benefit. |
| Coverage Gap | \$0 for all covered Part D drugs |
| Catastrophic Coverage | \$0 for all covered Part D drugs |

Other covered benefits



Allowance cards

| Benefit | |
|---------------------|--|
| Extra Benefits Card | <p>With this plan, you get an Extra Benefits Card to help you pay for everyday expenses. It will include:</p> <p>Extra Supports Wallet amount - \$200 monthly benefit amount (allowance) to pay for any of the following:</p> <ul style="list-style-type: none"> • Healthy food, over-the-counter (OTC) items, transportation, utilities, personal care items, pet supplies, rent or mortgage assistance <p>The monthly benefit amount will be available on the card the first day of each month. Any unused amount will roll over into the next month. The monthly amount can be rolled over through the end of the plan year, but, will not carryover into the next plan year. We have partnered with NationsBenefits to provide this benefit to you.</p> <p>For more information, you can contact NationsBenefits at 1-877-204-1817 (TTY: 711) or visit Aetna.NationsBenefits.com.</p> <p>Important: Plan not responsible for lost or stolen cards or fees associated with late utilities, rent, or mortgage payments.</p> |



Complementary and alternative medicine (CAM)

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|-------------------|---|---|
| Acupuncture | \$0 for Medicare-covered care Medicare coverage is limited to services to treat chronic low back pain. Routine acupuncture care isn't covered. | 40% for Medicare-covered care after your plan deductible |
| Chiropractic care | \$0 for Medicare-covered and routine care | 40% for Medicare-covered care after your plan deductible \$0 for routine care after your plan deductible |

Medicare coverage is limited to fixing a subluxation. This is when one or more of the bones in your spine move out of place. For routine services, we also cover up to twelve visits every year as necessary to meet your individual needs.



Diabetic supplies

We cover blood glucose monitors and diabetic test strips from **OneTouch®/LifeScan**. **Keep in mind:** We **don't** cover other brands unless you get approval from us first. Your doctor may need approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|-------------------|-----------------------|--|
| Diabetic supplies | \$0 | 0% – 20% after your plan deductible 0% for OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices 20% for non-OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices (prior authorization may be required) |



Fitness program

| Benefit | Your costs in our plan |
|-----------------------------|---|
| Physical and memory fitness | <p data-bbox="459 426 500 457">\$0</p> <p data-bbox="459 495 1463 726">You're eligible for a basic membership at SilverSneakers participating facilities. If you prefer to exercise at home, you can also access online classes or get an at-home fitness kit. This membership also includes classes and workshops taught by instructors trained in senior fitness, workout videos, a mobile app, and online fitness nutrition tips. You will also have access to online enrichment classes to support your health and wellness, as well as your mental fitness.</p> <p data-bbox="459 764 1455 924">You'll also have access to BrainHQ, an online memory fitness program. It contains brain exercises and assessments, as well as a library of information on activities that contribute to brain health. You can log in and use BrainHQ from your internet-connected computer, tablet, or smartphone (or all three) on a schedule that works best for you.</p> |



Foot care (podiatry services)

| Benefit | Your in-network costs | Your out-of-network costs |
|--------------------------|--|--|
| Foot exams and treatment | <p data-bbox="459 1186 963 1249">\$0 for Medicare-covered and routine care</p> <p data-bbox="459 1308 1227 1339">For routine services, we cover up to four visits every year.</p> | <p data-bbox="979 1186 1409 1287">40% for Medicare-covered care after your plan deductible \$0 for routine care</p> |



Home care and support

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|------------------------------------|-----------------------|---|
| Home health care | \$0 | 40% after your plan deductible |
| Personal emergency response system | \$0 | Our plan covers a personal emergency response system from LifeStation to provide you with 24/7 access to help in the event of an emergency. |



Medical equipment and supplies

Your doctor often needs approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|--|--|--------------------------------|
| Durable medical equipment (DME), like CPAP* machines, wheelchairs and oxygen | \$0 | 35% after your plan deductible |
| Prosthetics, such as braces and artificial limbs | \$0 | 40% after your plan deductible |
| Fall prevention | Up to \$150 every year for certain clinically appropriate home and bathroom safety devices that can improve your ability to move around your home. | |

*CPAP stands for “continuous positive airway pressure.”



Over-the-counter (OTC) benefit

| Benefit | Your in-network costs | Your out-of-network costs |
|---------|-----------------------|---|
| OTC kit | \$0 | You'll be mailed two kits of pre-selected OTC items. You don't need to order the kits, they will be mailed directly to you. |



Substance abuse

Your doctor may need approval from us before we cover these services. This is called **prior authorization** or pre-certification.

| Benefit | Your in-network costs | Your out-of-network costs |
|------------------------------------|-----------------------|--------------------------------|
| Outpatient substance abuse therapy | \$0 | 40% after your plan deductible |



24-Hour Nurse Line

Talk to a registered nurse anytime, day or night.

| Benefit | Your costs in our plan |
|------------|------------------------|
| Nurse Line | \$0 |

Special Supplemental Benefits Chart

Our plan offers additional benefits to members with qualifying conditions. See the EOC for a full list of eligibility criteria.

Eligibility Criteria

If you are diagnosed with one or more of the conditions listed in the EOC and meet certain criteria, you may be eligible for additional benefits under our plan. Member eligibility will be determined through medical claims submission. Provider-submitted medical claims with a diagnosis supporting the conditions listed in the EOC will qualify you for eligibility.

Food as Medicine:

Our plan has contracted with a company named “FarmboxRx” to assist you in maintaining a healthy diet and meeting your nutritional needs.

If you are eligible, you will receive a letter to let you know how to set up this benefit. You may schedule 1 fresh fruit and vegetable box every quarter during the plan year.

Summary of Medicaid-Covered Benefits

People who qualify for Medicare and Medicaid (also called “Medical Assistance”) are known as dual eligibles. As a dual eligible, you are eligible for benefits under both the Federal Medicare program and the Pennsylvania Medicaid program.

The benefits described in the Covered Medical and Hospital Benefits section (earlier in this document) are covered by Aetna Medicare Dual Preferred (PPO D-SNP). The services listed below are offered under the Pennsylvania State Medicaid Plan for recipients 21 years of age and older who are eligible for Medical Assistance benefits and Medicare as Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility or benefits call 1-800-692-7462.

Pennsylvania’s Current Medicaid State Plan Benefits and Home and Community Based Services

Adult Benefit Package**

| Services | Adult Benefit Package |
|--|--|
| Category 1: Ambulatory Services | |
| Primary Care Provider | No limits |
| Physician Services and Medical and Surgical Services provided by a Dentist | No limits |
| Certified Registered Nurse Practitioner | No limits |
| Federally Qualified Health Center/Rural Health Clinic | No limits except for Dental Care Services as described below |
| Independent Clinic | No limits |
| Outpatient Hospital Clinic | No limits |
| Podiatrist Services | No limits |
| Chiropractor Services | No limits |
| Optometrist Services | 2 visits (exams) per calendar year |
| Hospice Care | The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period. |
| Radiology (For example: X-Rays, MRIs, and CTs) | No limits |

| | |
|----------------------|---|
| Dental Care Services | <p>Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation.</p> <p>Key Limitations: Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime.</p> <p>Denture relines - either FULL or partial, limited to 1 arch every 2 calendar years.</p> <p>Oral exams - 1 per 180 days</p> <p>Dental prophylaxis – 1 per 180 days</p> <p>Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years.</p> <p>Crowns, Periodontics and Endodontics only via approved benefit limit exception.</p> |
|----------------------|---|

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|--|---|
| Outpatient Hospital Short Procedure Unit (SPU) | No limits |
| Outpatient Ambulatory Surgical Center (ASC) | No limits |
| Non-Emergency Medical Transport | Only to and from Medicaid covered services. |
| Family Planning Clinic, Services and Supplies | No limits |
| Renal Dialysis | <p>Initial training for home dialysis is limited to 24 sessions per patient per calendar year.</p> <p>Backup visits to the facility limited to no more than 75 per calendar year.</p> |

Category 2: Emergency Services

| | |
|----------------|-----------|
| Emergency Room | No limits |
| Ambulance | No limits |

Category 3: Hospitalization

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|--------------------------------|-----------|
| Inpatient Acute Hospital | No limits |
| Inpatient Rehab Hospital | No limits |
| Inpatient Psychiatric Hospital | No limits |
| Inpatient Drug & Alcohol | No limits |

Category 4: Maternity and Newborn

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|--|-----------|
| Maternity – Physician, Certified Nurse Midwives, Birth Centers | No limits |
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Category 5: Mental Health and Substance Abuse (Behavioral Health)

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| Outpatient Psychiatric Clinic | No limits |
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| Mobile Mental Health Treatment | No limits |
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| Outpatient Drug and Alcohol Treatment | No limits |
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| Methadone Maintenance | No limits |
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| Clozapine | No limits |
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| Psychiatric Partial Hospital | No limits |
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| Peer Support | No limits |
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| Crisis | No limits |
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| Targeted Case Management – other than Behavioral Health | Limited to individuals identified in the target group (No limits). |
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| Targeted Case Management – Behavioral Health Only | Limited to individuals with Serious Mental Illness (SMI) only (No limits). |
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Category 6: Prescription Drugs

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|--------------------|-----------|
| Prescription Drugs | No limits |
|--------------------|-----------|

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|-------------------------|-----------|
| Nutritional Supplements | No limits |
|-------------------------|-----------|

Category 7: Rehabilitation and Habilitation Services and Devices

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|--------------------------|----------------------------|
| Skilled Nursing Facility | 365 days per calendar year |
|--------------------------|----------------------------|

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|---|---|
| Home Health Care includes nursing, aide and therapy services. | Unlimited for first 28 days; limited to 15 days every month thereafter. |
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|---------------------|--|
| ICF/IID and ICF/ORC | Requires an institutional level of care (No limits). |
|---------------------|--|

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|---------------------------|-----------|
| Durable Medical Equipment | No limits |
|---------------------------|-----------|

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|--|--|
| Prosthetics and Orthotics | <p>Orthopedic Shoes and Hearing Aids are not covered.</p> <p>Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications.</p> <p>Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint.</p> <p>Coverage for low vision aids and eye prostheses is limited to 1 per 2 calendar years.</p> <p>Coverage for an eye ocular is limited to 1 per calendar year.</p> |
| Eyeglass Lenses | Limited to individuals diagnosed with aphakia - 4 lenses per calendar year. |
| Eyeglass Frames | Limited to individuals diagnosed with aphakia - 2 frames per calendar year. Deluxe frames not included. |
| Contact Lenses | Limited to individuals diagnosed with aphakia - 4 lenses per calendar year. |
| Medical Supplies | No limits |
| Therapy (physical, occupational, speech) – Rehabilitative | Only when provided by a hospital, outpatient clinic, or home health provider. |
| Therapy (physical, occupational, speech) – Habilitative | Only when provided by a hospital, outpatient clinic, or home health provider. |
| Category 8: Laboratory Services | |
| Laboratory | No limits |
| Category 9: Preventative/Wellness Services and Chronic Care | |
| Tobacco Cessation*** | 70, 15-minute units per calendar year |

All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule.

**Children’s benefit plan will include all medically necessary services without limitation.

***Tobacco cessation is one of the preventive services as recommended by the US Preventative Services Task Force. For a FULL listing of preventative services beyond tobacco cessation, please contact your MCO.

Home and Community-Based Services (HCBS)

| Services | Limits |
|---|--|
| Adult Daily Living Services Assistive Technology Behavior Therapy Benefits Counseling Career Assessment Cognitive Rehabilitation Therapy Community Integration Community Transition Services Counseling Employment Skills Development Home Adaptations Home Delivered Meals Home Health Aide Home Health – Nursing Home Health – Occupational Therapy Home Health – Physical Therapy Home Health – Speech and Language Therapy Job Coaching Job Finding Non-Medical Transportation Nutritional Counseling Participant-Directed Community Supports Participant-Directed Goods and Services Personal Assistance Services Personal Emergency Response System (PERS) Pest Eradication Residential Habilitation Respite Service Coordination Specialized Medical Equipment and Supplies | Under Community Integration Each distinct goal may not be more than twenty-six (26) weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved. However, the Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks. Community Transition Services are limited to an aggregate of \$4,000 per participant, per lifetime, as pre- authorized by the State Medicaid Agency program office. Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval. Under Specialized Medical Equipment and Supplies non-covered items include: All prescription and over-the-counter |

Structured Day Habilitation
TeleCare
Vehicle Modification

medications, compounds and solutions (except wipes and barrier cream)

Items covered under third party payer liability

Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability

Food, food supplements, food substitutes (including formulas), and thickening agents

Eyeglasses, frames, and lenses

Dentures

Any item labeled as experimental that has been denied by Medicare and/or Medicaid

Recreational or exercise equipment and adaptive devices for such

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

Contact quick reference

| Contact name | Phone number (TTY: 711) | Website |
|---|--|---|
| Aetna: Before you enroll | 1-833-859-6031 | AetnaMedicare.com |
| Aetna: After you enroll | Member Services: 1-866-409-1221 | AetnaMedicare.com/H5522-024 |
| Your agent/broker (use this space to write down your agent/broker's phone number) | | |
| Find a network doctor, hospital, or pharmacy | 1-866-409-1221 | AetnaMedicare.com/findprovider |
| 24-Hour Nurse Line | 1-855-493-7019 | Please call |
| Access2Care (transportation) | 1-855-814-1699 (TTY: 711) | Please call |
| Aetna (dental) | 1-866-409-1221 | AetnaMedicare.com/dental |
| BrainHQ (memory fitness) | 1-888-845-0565 (TTY: 711) | Aetna.BrainHQ.com |
| EyeMed (vision) | 1-844-486-3485 (TTY: 711) | AetnaMedicareVision.com |
| LifeStation® | 1-855-798-9948 | Please call |
| Nations (Extra Benefits Card) | 1-877-204-1817 (TTY: 711) | Aetna.NationsBenefits.com |
| NationsHearing | 1-877-225-0137 (TTY: 711 for the hearing and speech impaired) | Aetna.NationsBenefits.com/Hearing |
| OneTouch/LifeScan | 1-877-764-5390 Brochure code: 123AET200 | OneTouch.orderpoints.com |
| SilverSneakers | 1-888-423-4632 (TTY/TDD: 711) | SilverSneakers.com |

Note: If you obtain covered services from an out-of-network physician or provider who does not accept Medicare assignment, you will be responsible for the cost sharing shown above, plus any difference between the amount we pay the provider and the Medicare limiting charge. If you obtain durable medical equipment from an out-of-network supplier who does not accept Medicare assignment, the plan will pay based on the billed amount and you will be responsible for the cost sharing shown above.

Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health family of companies.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our member services number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

For mail order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call 1-866-409-1221 (TTY: 711) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

Participating 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.

The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

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If your plan's Extra Benefits Card includes roll-over, any unused amount will rollover into the next month. The monthly amount can be rolled over through the end of the plan year but will not carry over into the next plan year.

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-833-859-6031 (TTY: 711)**. From October 1 to March 31, you can call us 7 days a week from 8 AM to 8 PM local time. From April 1 to September 30, we're here Monday through Friday from 8 AM to 8 PM local time.

Understanding the benefits

- The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [AetnaMedicare.com](https://www.aetna.com/medicare) or call **1-833-859-6031 (TTY: 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding important rules

- Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part B premium is covered for full-dual members.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Multi-Language Insert Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-409-1221. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-409-1221. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-409-1221。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-409-1221。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-409-1221. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-409-1221. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-409-1221. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-409-1221. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-409-1221. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-409-1221. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-409-1221. سيقوم شخص ما بتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-409-1221 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-409-1221. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-409-1221. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-409-1221. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-409-1221. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-866-409-1221. にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele 'ōlelo kā mākou i mea e pane 'ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā'au lapa'au paha. I mea e loa'a ai ke kōkua māhele 'ōlelo, e kelepona mai iā mākou ma 1-866-409-1221. E hiki ana i kekahi mea 'ōlelo Pelekānia/'Ōlelo ke kōkua iā 'oe. He pōmaika'i manuahi kēia.

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Form CMS-10802
(Expires 12/31/25)

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, our health plan provides auxiliary aids and services, free of charge, when necessary, to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Our health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, visit our website, call the phone number listed in this material or on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your *Evidence of Coverage*). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

傳統漢語(中文) **(CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。