Aetna Medicare Select Extra (HMO-POS)
H1609 - 028 | $0 Plan Premium

2026 Summary of Benefits

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

Already a member?
Call 1-833-570-6670 (TTY: 711)
8 AM to 8 PM, 7 days a week
An Aetna team member will answer your call.

Keep in mind

This is a summary of the services we cover from January 1, 2026 through December 31, 2026.

Need a complete list of what we cover and any limitations? Just visit **AetnaMedicare.com/H1609-028** where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

2026-H1609.028.1

AetnaMedicare.com
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aetna®

Are you eligible to enroll?

To join Aetna Medicare Select Extra (HMO-POS), you must:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:
  Florida: Broward, Charlotte, Clay, Duval, Hillsborough, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pinellas, Polk, Sarasota, Seminole, St. Johns, St. Lucie

What you should know

- **Plan type:** Aetna Medicare Select Extra (HMO-POS) is a POS 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.
- **Primary Care Provider (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.
- **Network:** Our plan has a network of select providers to provide you with patient-centered care, coordinated services and enhanced provider communication. To locate a network provider you may contact Member Services or search the online provider directory.
- **Referrals:** Aetna Medicare Select Extra (HMO-POS) 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 provider in order to see you.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit **AetnaMedicare.com/H1609-028**. For coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at **medicare.gov/medicare-and-you**, or get a copy by calling 1-800-MEDICARE (**1-800-633-4227**) (**TTY: 1-877-486-2048**), 24 hours a day, 7 days a week.

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

Out-of-pocket costs	
Monthly plan premium	$0 You must continue to pay your Medicare Part B premium.
Plan deductible	No in-network deductible. $500 for certain out-of-network services. Your deductible is what you'll pay before we begin to pay for services.
MOOP	$6,750 for in-network services $10,100 for in- and out-of-network services combined Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.

Medical and hospital benefits

Hospital coverage

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Inpatient (unlimited number of days)	$375 per day, days 1-5; $0 per day, days 6-90; $0 for additional days	50% per stay after your plan deductible is met
Outpatient hospital observation services	$375 copay	50% coinsurance after your plan deductible is met
Outpatient hospital	$350 copay	50% coinsurance after your plan deductible is met
Ambulatory surgical center	$300 copay	50% coinsurance after your plan deductible is met

Primary Care Provider (PCP) and specialist visits

Benefit	Your in-network costs	Your out-of-network costs
PCP	$0 copay	Not Covered
Specialist	$30 copay	$70 copay after your plan deductible is met

Preventive, emergency and urgent care

Benefit	Your in-network costs	Your out-of-network costs
Preventive care	$0 copay For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.	$0 copay
Emergency and urgent care (inside the U.S.)	$130 copay for emergency care $30 copay for urgent care	$130 copay for emergency care $30 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	$130 copay for emergency care $130 copay for urgent care $250 copay for ambulance Maximum coverage: $250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency ambulance)	$130 copay for emergency care $130 copay for urgent care $250 copay for ambulance

Diagnostic services, labs, imaging

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic tests and procedures	$0 - $200 copay $0 copay for services performed at a non-hospital facility $200 copay for services performed at a hospital facility $0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing	50% coinsurance after your plan deductible is met
Lab services	$0 - $30 copay $0 copay for services performed at a non-hospital facility and for certain lab services including hemoglobin A1c, urine protein, prothrombin (protime), urine albumin, fecal immunochemical test (FIT), kidney health evaluation for members with diabetes (KED) and COVID-19 testing $30 copay for services performed at a hospital facility	50% coinsurance after your plan deductible is met
Diagnostic radiology services, such as CT/CAT scan and MRI	$0 - $200 copay $0 copay for services performed at a non-hospital facility $200 copay for services performed at a hospital facility	50% coinsurance after your plan deductible is met
Outpatient x-rays	$10 copay	50% coinsurance after your plan deductible is met

Hearing services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic hearing exam	$30 copay	Not Covered
Routine hearing exam	$0 copay You get one routine hearing exam every year with a provider in the NationsHearing® network.	Not Covered
Hearing aids	You get an annual benefit amount (allowance) of $1,000 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through a NationsHearing network provider.	Not Covered

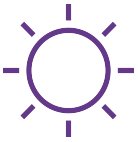
Dental services

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Dental services (non-Medicare covered)	$0 copay for covered services	You must use an in-network provider for your dental services to be covered.
	You get an annual benefit amount (allowance) of $1,000 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, cleanings, fillings, extractions, crowns, dentures, and more. We have teamed up with Liberty Dental to provide your dental coverage. This benefit uses the Liberty Dental network, which is different from your medical network, for covered services. If you choose a provider outside of the Liberty Dental network, services will not be covered. See EOC for details on exclusions and limitations.	

Vision services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic eye exam (includes diabetic eye exams)	$0 copay	Not Covered
Glaucoma screening	$0 copay	Not Covered
Routine eye exam (one exam every year)	$0 copay with an iCare provider	Not Covered
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $100 for covered prescription eyewear. We have teamed up with iCare to provide this benefit. You can choose to use a provider outside of the iCare 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 provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Inpatient psychiatric hospital stay	$375 per day, days 1-5; $0 per day, days 6-90 Our plan covers up to 190 days per benefit period.	50% per stay after your plan deductible is met
Outpatient mental health therapy	$35 copay for individual sessions $30 copay for group sessions	Not Covered Not Covered
Outpatient psychiatric therapy	$35 copay for individual sessions $30 copay for group sessions	Not Covered Not Covered

Skilled nursing facility (SNF) and therapy

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification. 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 per day, days 1-20; $218 per day, days 21-100 Our plan covers up to 100 days per benefit period.	50% per stay after your plan deductible is met
Physical and speech therapy	$35 copay	Not Covered
Occupational therapy	$35 copay	Not Covered

Ambulance and routine transportation

Your provider needs approval from us before we cover non-emergency transportation by fixed wing aircraft. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Ambulance (ground or air, one-way trip)	$250 copay for ground ambulance services 20% coinsurance for air ambulance services	$250 copay for ground ambulance services after your plan deductible is met 20% coinsurance for air ambulance services after your plan deductible is met
Routine, non-emergency transportation	Not Covered	Not Covered

Medicare Part B drugs

Medicare Part B only covers a limited number of medicines under certain conditions. These medicines are often given to you in your provider'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 provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Chemotherapy drugs	0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	Not Covered
Part B Insulin	$35 copay	Not Covered
Other Part B drugs	0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	Not Covered

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. Some drugs require **prior authorization**. This means you must get approval from us first before we'll cover them.

Prescription drug costs (your costs may be lower if you qualify for "Extra Help")

Formulary name: B2 (you can use this when referencing our list of covered drugs).

Deductible phase

You'll pay the plan's negotiated drug cost up to the deductible limit of $615. The deductible applies to drugs on Tiers 3, 4, and 5.

Initial coverage phase

The plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription filled. You will pay the lesser of the listed copay/coinsurance below or the negotiated cost of the drug. These cost shares may also apply to home infusion drugs when obtained through your Part D benefit. Costs may differ based on pharmacy type or status.

One-month Supply

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Preferred Retail	Standard Retail	Preferred Mail	Standard Mail	Long-Term Care (LTC)
	30-day	30-day	30-day	30-day	31-day
Tier 1: Preferred Generic	$0	$2	$0	$2	$2
Tier 2: Generic	$0	$12	$0	$12	$12
Tier 3: Preferred Brand	24%	24%	24%	24%	24%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%
Tier 5: Specialty	25%	25%	25%	25%	25%

Long-term Supply

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Preferred Retail	Standard Retail	Preferred Mail	Standard Mail
	100-day	100-day	100-day	100-day
Tier 1: Preferred Generic	$0	$6	$0	$6
Tier 2: Generic	$0	$36	$0	$36
Tier 3: Preferred Brand	24%	24%	24%	24%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%
Tier 5: Specialty	A long-term supply is not available for drugs on Tier 5.			

Out-of-pocket threshold

$2,100 is the maximum amount you will pay for your yearly Part D out-of-pocket costs.

Catastrophic coverage phase

In this phase, the plan pays the full cost for your covered Part D drugs.

You'll pay $0 for generic and brand name drugs in this phase.

Insulins and vaccines

Important message about what you pay for Part D insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or Part D phase you are in, even if you haven't paid your deductible.

Important message about what you pay for Part D vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible.

Check your formulary guide for a list of covered insulins and vaccines.

Other covered benefits

Aetna Medicare Extra Benefits Card

You get an **Aetna Medicare Extra Benefits Card** to help pay for certain everyday expenses.

Benefit	
CVS Over-the-Counter (OTC) Wallet	You get a $35 quarterly benefit amount (allowance). You can use your CVS Over-the-Counter (OTC) Wallet to help pay for certain OTC health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. Approved products can be purchased in-store at participating CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®. **Important:** • If you received an Extra Benefits Card in 2025 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2026 plan year. • If you are a new member or were not enrolled in a plan with an Extra Benefits Card in 2025, you should get a new card before your plan begins. • If you changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.

Alternative medicine

Benefit	Your in-network costs	Your out-of-network costs
Acupuncture	$30 copay for Medicare-covered acupuncture visits	$70 copay for Medicare-covered acupuncture visits after your plan deductible is met
	Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.	
Chiropractic services	$15 copay for Medicare-covered chiropractic visits	50% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met
	Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.	

Diabetic supplies

We exclusively cover **Accu-Chek/Roche and TRUE/Trividia** blood glucose meters and test strips as our preferred diabetic supplies.

Benefit	Your in-network costs	Your out-of-network costs
Diabetic supplies	0% - 20% coinsurance 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization	Not Covered

Fitness benefit

Benefit	Your costs in our plan
Annual physical fitness membership	$0 copay You get a basic membership to any SilverSneakers® participating fitness facility. If you prefer to exercise at home, you may order one at-home fitness kit per year through SilverSneakers. If you do not reside near a participating facility, online fitness classes are available at no additional cost to you.

Foot care (podiatry services)

Benefit	Your in-network costs	Your out-of-network costs
Foot exams and treatment	$30 copay for Medicare-covered podiatry visits	50% coinsurance for Medicare-covered podiatry visits after your plan deductible is met

Home care and support

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Home health care	$0 copay	50% coinsurance after your plan deductible is met

Medical equipment and supplies

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Durable medical equipment (DME), such as wheelchairs, crutches, oxygen equipment, and continuous glucose monitors (CGMs)	0% - 20% coinsurance 0% coinsurance for continuous glucose monitors 20% coinsurance for all other Medicare-covered DME items	Not Covered
Prosthetics, such as braces and artificial limbs	20% coinsurance	Not Covered

Resources For Living®

Benefit	
Resources For Living	Resources For Living helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities, and more.

Substance use disorder services

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Outpatient substance use disorder services	$35 copay for individual sessions $30 copay for group sessions	Not Covered Not Covered

24-Hour Nurse Line

You can talk to a registered nurse anytime to discuss health-related questions. While only your doctor can diagnose, prescribe, or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics.

Benefit	Your costs in our plan
24-Hour Nurse Line	$0 copay

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs 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.

Aetna is part of the CVS Health® family of companies.

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

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in: Suburban Arizona, Urban Kansas, Urban Missouri, Rural Michigan, Rural Nebraska, Rural North Dakota, Suburban West Virginia, and Suburban Puerto Rico. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call **1-833-859-6031** (**TTY: 711**) or consult the online pharmacy directory at **AetnaMedicare.com/findpharmacy**.

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 **1-833-570-6670** (**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.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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.

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 (**1-800-633-4227**) (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.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

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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** 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.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on this document. (English)

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للحصول على خدمات اللغة مجانًا، اتصل بالرقم المذكور في هذه الوثيقة. (Arabic)

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa doookumentii kanarra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro indiqué sur ce document. (French)

Pou jwenn sèvis lang san ou pa peye anyen, rele nimewo ki sou dokiman sa a. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer in diesem Dokument an. (German)

Inā ake ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe i ka helu ma kēia palapala. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj ntawm daim ntawv no. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato in questo documento. (Italian)

無料の言語サービスをご利用いただくには、この書類に記載されている番号にお電話ください。 (Japanese)

လၢကမၤန့ၢ် ကိုၢ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိဉ်လၢ်ဘူဉ်လၢ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီဉ်ဂံၢ် လၢအအိဉ်ဖဲလံာ်တီလံာ်မီအံၤ အဖီခိဉ်နှဉ်တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພື່ອເຂົ້າເຖິງການ ບໍລິການພາສາໂດຍ ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, ໃຫ້ໂທຫາເບີໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

Ligue para o número indicado neste documento para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que aparece en este documento. (Spanish)

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa dokumentong ito. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)

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