



# 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](tel:1-833-859-6031) (TTY: [711](tel: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 [1-844-498-1860](tel:1-844-498-1860) (TTY: [711](tel: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/H1609-049](https://www.aetna.com/H1609-049) where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

## Are you eligible to enroll?

### To join Aetna Medicare Dual Select (HMO 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 county:  
**Florida:** Polk
- Be in a "Medicare Savings Program" (MSP) or qualify for State Medicaid benefits. See the table below for eligibility categories.

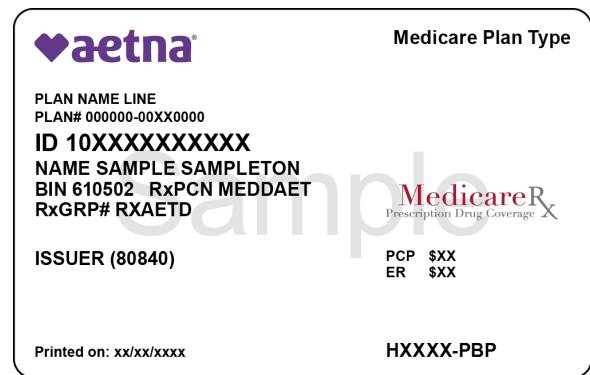
### Better health is a team effort

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 provider appointments, arrange rides, and work with you to meet your personal needs.
- We have teamed up with BeneLynk to assist you with your state Medicaid benefits and Extra Help for prescription drug assistance.

| Eligibility category                                       | 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 (SLMB)           | Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)                                                                                                            |
| Specified Low-Income Medicare Beneficiary Plus (SLMB Plus) | Helps pay Medicare Part B premiums and possibly Part A. 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. |
| 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.                                                         |
| Qualified Disabled and Working Individual (QDWI)           | Helps pay Medicare Part A premiums.                                                                                                                                                                                 |
| Qualifying Individual (QI)                                 | Helps pay Medicare Part B premiums.                                                                                                                                                                                 |

Be sure to show your Aetna® member ID card when you visit the provider or pharmacy.



## What you should know

- **Plan type:** Aetna Medicare Dual Select (HMO D-SNP) is a D-SNP plan. This is a Medicare Advantage plan that covers prescription drugs.
- **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 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:** Usually, your PCP must give approval before you use other network providers. You don't need a referral for emergency or urgently needed care.
- **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/H1609-049](https://www.aetna.com/Medicare/H1609-049). For coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you), or get a copy by calling 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)) (TTY: [1-877-486-2048](tel: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                                                                                                                                                                                                                                                                                            |
| Plan deductible      | \$0                                                                                                                                                                                                                                                                                            |
| MOOP                 | <div>\$9,250</div> <div>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.</div> |

## Medical and hospital benefits

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **\$0 copayment amount**.



### Hospital coverage

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

| Benefit                                  | Your costs in our plan                                                                                                                                                                                                                                                              |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient (unlimited number of days)     | \$0 copay - \$150 per day, days 1-5; \$0 per day, days 6-90; \$0 for additional days <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$150 per day, days 1-5; \$0 per day, days 6-90 for SLMB, QI, and QDWI members</li> </ul> |
| Outpatient hospital observation services | \$0 - \$150 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$150 copay for SLMB, QI, and QDWI members</li> </ul>                                                                                                        |
| Outpatient hospital                      | \$0 - \$150 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$150 copay for SLMB, QI, and QDWI members</li> </ul>                                                                                                        |
| Ambulatory surgical center               | \$0 - \$100 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$100 copay for SLMB, QI, and QDWI members</li> </ul>                                                                                                        |



### Primary Care Provider (PCP) and specialist visits

| Benefit    | Your costs in our plan                                                                                                                                                     |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PCP        | \$0 copay                                                                                                                                                                  |
| Specialist | \$0 - \$20 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$20 copay for SLMB, QI, and QDWI members</li> </ul> |



### Preventive, emergency and urgent care

| Benefit                                                                     | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Preventive care                                                             | <p>\$0 copay</p> <p>For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.</p>                                                                                                                                                                                                                                                                |
| Emergency and urgent care (inside the U.S.)                                 | <p>\$0 - \$115 copay for emergency care</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$115 copay for SLMB, QI, and QDWI members</li> </ul> <p>\$0 - \$40 copay for urgent care</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$40 copay for SLMB, QI, and QDWI members</li> </ul> |
| Emergency and urgent care, including emergency ambulance (outside the U.S.) | <p>\$0 copay for emergency care</p> <p>\$0 copay for urgent care</p> <p>\$0 copay for ambulance</p> <p>Maximum coverage: \$250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency ambulance)</p>                                                                                                                                                         |



### Diagnostic services, labs, imaging

Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification. You may have to get a **referral from your PCP** before you can receive these services.

| Benefit                                                    | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic tests and procedures                            | \$0 copay or \$0 - \$40 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$0 copay for services performed at a non-hospital facility for SLMB, QI, and QDWI members</li> <li>• \$40 copay for services performed at a hospital facility for SLMB, QI, and QDWI members</li> </ul> \$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing |
| Lab services                                               | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Diagnostic radiology services, such as CT/CAT scan and MRI | \$0 copay or \$0 - \$200 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$0 copay for services performed at a non-hospital facility for SLMB, QI, and QDWI members</li> <li>• \$200 copay for services performed at a hospital facility for SLMB, QI, and QDWI members</li> </ul>                                                                                                                                                        |
| Outpatient x-rays                                          | \$0 copay or \$0 - \$25 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$0 copay for services performed at a non-hospital facility for SLMB, QI, and QDWI members</li> <li>• \$25 copay for services performed at a hospital facility for SLMB, QI, and QDWI members</li> </ul>                                                                                                                                                          |



### Hearing services

| Benefit                 | Your costs in our plan                                                                                                                                                                                                                    |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic hearing exam | \$0 - \$20 copay <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$20 copay for SLMB, QI, and QDWI members</li> </ul>                                                                |
| Routine hearing exam    | \$0 copay<br>You get one routine hearing exam every year with a provider in the NationsHearing® network.                                                                                                                                  |
| Hearing aids            | You get an annual benefit amount (allowance) of \$1,250 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. |



### Dental services

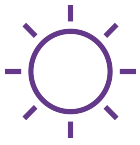
Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit                                | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dental services (non-Medicare covered) | \$0 copay for covered services<br>You get an annual benefit amount (allowance) of \$2,500 for covered services. You are responsible for any costs over this amount.<br><br>Covered services include oral exams, cleanings, fillings, extractions, crowns, dentures, and more. We have teamed up with Liberty Dental to provide your dental coverage.<br><br>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.<br><br>See EOC for details on exclusions and limitations. |



Vision services

| Benefit                                           | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Glaucoma screening                                | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Routine eye exam (one exam every year)            | \$0 copay with an iCare provider                                                                                                                                                                                                                                                                                                                                                                                                  |
| Contacts and eyeglasses                           | <p>You get an annual benefit amount (allowance) of \$300 for covered prescription eyewear.</p> <p>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.</p> |



### Mental health services

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

| Benefit                             | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient psychiatric hospital stay | <p>\$0 copay - \$150 per day, days 1-5; \$0 per day, days 6-90</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$150 per day, days 1-5; \$0 per day, days 6-90 for SLMB, QI, and QDWI members</li> </ul> <p>Our plan covers up to 190 days per benefit period.</p>                                                                                                                                                                         |
| Outpatient mental health therapy    | <p>\$0 - \$15 copay for individual sessions</p> <ul style="list-style-type: none"> <li>• \$0 copay for individual sessions for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$15 copay for individual session for SLMB, QI, and QDWI members</li> </ul> <p>\$0 - \$10 copay for group sessions</p> <ul style="list-style-type: none"> <li>• \$0 copay for group sessions for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$10 copay for group session for SLMB, QI, and QDWI members</li> </ul>  |
| Outpatient psychiatric therapy      | <p>\$0 - \$15 copay for individual sessions</p> <ul style="list-style-type: none"> <li>• \$0 copay for individual sessions for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$15 copay for individual sessions for SLMB, QI, and QDWI members</li> </ul> <p>\$0 - \$10 copay for group sessions</p> <ul style="list-style-type: none"> <li>• \$0 copay for group sessions for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$10 copay for group session for SLMB, QI, and QDWI members</li> </ul> |



### 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. You may have to get a **referral from your PCP** before you can receive these services. Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

| Benefit                     | Your costs in our plan                                                                                                                                                                                                                                                                                                            |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SNF care                    | <p>\$0 copay - \$0 per day, days 1-20; \$218 per day, days 21-100</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$0 per day, days 1-20; \$218 per day, days 21-100 for SLMB, QI, and QDWI members</li> </ul> <p>Our plan covers up to 100 days per benefit period.</p> |
| Physical and speech therapy | <p>\$0 - \$10 copay</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$10 copay for SLMB, QI, and QDWI members</li> </ul>                                                                                                                                                 |
| Occupational therapy        | <p>\$0 - \$5 copay</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$5 copay for SLMB, QI, and QDWI members</li> </ul>                                                                                                                                                   |



### 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 costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ambulance<br>(ground or air, one-way trip) | <p>\$0 - \$225 copay for ground ambulance services</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$225 copay for SLMB, QI, and QDWI members</li> </ul> <p>\$0 copay - 20% coinsurance for air ambulance services</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• 20% coinsurance for SLMB, QI, and QDWI members</li> </ul> |
| Routine, non-emergency transportation      | <p>\$0 copay</p> <p>You get up to 48 one-way trips every year to and from plan-approved locations (up to 60 miles each trip). Examples of plan-approved locations include medical offices and urgent care centers within the plan's service area. We have teamed up with ModivCare to provide this benefit.</p>                                                                                                                                |



### 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 costs in our plan                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Chemotherapy drugs | <p>\$0 copay or 0% - 20% coinsurance</p> <p>\$0 copay for some members, based on your level of Medicaid eligibility</p> <p>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• 0% - 20% coinsurance for SLMB, QI, and QDWI members</li> </ul> |
| Part B Insulin     | <p>\$0 - \$35 copay</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$35 copay for SLMB, QI, and QDWI members</li> </ul>                                                                                                                                                                                                                                    |
| Other Part B drugs | <p>\$0 copay or 0% - 20% coinsurance</p> <p>\$0 copay for some members, based on your level of Medicaid eligibility</p> <p>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• 0% - 20% coinsurance for SLMB, QI, and QDWI members</li> </ul> |

## 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

#### Formulary Name

B2 (You can use this when referencing our list of covered drugs.)

### If you qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:

#### Deductible

\$0

#### Initial coverage phase

Low Income Subsidy (LIS) cost sharing during the Initial coverage phase (copayments or coinsurance may vary depending on your level of "Extra Help"):

Covered generic drugs (including brand drugs treated as generic): \$0, \$1.60, or \$5.10.

For all other covered drugs: \$0, \$4.90, or \$12.65.

### If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:

#### 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:

|                            | Standard<br>Retail | Standard<br>Mail | Long-Term Care<br>(LTC) |
|----------------------------|--------------------|------------------|-------------------------|
|                            | 30-day             | 30-day           | 31-day                  |
| Tier 1: Preferred Generic  | \$0                | \$0              | \$0                     |
| Tier 2: Generic            | \$0                | \$0              | \$0                     |
| Tier 3: Preferred Brand    | 22%                | 22%              | 22%                     |
| Tier 4: Non-Preferred Drug | 25%                | 25%              | 25%                     |
| Tier 5: Specialty          | 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:

|                            | Standard<br>Retail                                       | Standard<br>Mail |
|----------------------------|----------------------------------------------------------|------------------|
|                            | 100-day                                                  | 100-day          |
| Tier 1: Preferred Generic  | \$0                                                      | \$0              |
| Tier 2: Generic            | \$0                                                      | \$0              |
| Tier 3: Preferred Brand    | 22%                                                      | 22%              |
| Tier 4: Non-Preferred Drug | 25%                                                      | 25%              |
| Tier 5: Specialty          | A long-term supply is not available for drugs on Tier 5. |                  |

You can get a 30, 60, or 100-day supply of most of your drugs through network retail and mail-order pharmacies. This includes home infusion drugs obtained through your Part D benefit. Note: Specialty drugs have a 30-day limit.

### 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                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Over-the-Counter (OTC) Wallet | <p>You get a \$215 monthly benefit amount (allowance) on the Aetna Medicare Extra Benefits Card.</p> <p>You can use your 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 locations including CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®.</p> <p><b>Important:</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li><li>• If you changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.</li></ul> |



### Alternative medicine

| Benefit               | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Acupuncture           | <p>\$0 - \$20 copay for Medicare-covered acupuncture visits</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$20 copay for SLMB, QI, and QDWI members</li> </ul> <p>Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.</p>                                                                                                                                                          |
| Chiropractic services | <p>\$0 - \$15 copay for Medicare-covered chiropractic visits</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$15 copay for SLMB, QI, and QDWI members</li> </ul> <p>\$0 copay for non-Medicare covered chiropractic visits</p> <p>Medicare coverage is limited to fixing a subluxation. For non-Medicare covered services, we also cover up to twenty four visits every year. Your provider must determine medical necessity for non-Medicare covered services.</p> |



### Diabetic supplies

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

| Benefit           | Your costs in our plan |
|-------------------|------------------------|
| Diabetic supplies | 0% coinsurance         |

**Fitness benefit**

| Benefit                            | Your costs in our plan                                                                                                                                                                                                                                                                                                                     |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Annual physical fitness membership | <p>\$0 copay</p> <p>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.</p> |

**Foot care (podiatry services)**

| Benefit                  | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Foot exams and treatment | <p>\$0 - \$20 copay for Medicare-covered podiatry visits</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$20 copay for SLMB, QI, and QDWI members</li> </ul> <p>\$0 copay for non-Medicare covered podiatry visits</p> <p>For non-Medicare covered services, we cover up to twenty four visits every year.</p> |



### 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 costs in our plan                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Home health care                   | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                 |
| Meal benefit (post-discharge)      | \$0 copay for meals<br><br>After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 28 freshly prepared meals for a 14-day period. These meals are provided to help support your recovery or manage your health conditions. We have teamed up with NationsMarket™ to provide this benefit. |
| Personal emergency response system | \$0 copay<br><br>Our plan covers a medical alert response system from LifeStation to provide you with 24/7 access to help in the event of a fall or an emergency.                                                                                                                                                                                                                                         |



### 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 costs in our plan                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| Durable medical equipment (DME), such as wheelchairs, crutches, oxygen equipment, and continuous glucose monitors (CGMs) | 0% coinsurance                                                                                                             |
| Prosthetics, such as braces and artificial limbs                                                                         | 0% coinsurance                                                                                                             |
| Fall prevention                                                                                                          | You will receive a \$150 annual benefit amount (allowance) to purchase certain approved home and bathroom safety products. |



### 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 costs in our plan                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient substance use disorder services | <p>\$0 - \$15 copay for individual sessions</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$15 copay for SLMB, QI, and QDWI members</li> </ul> <p>\$0 - \$10 copay for group sessions</p> <ul style="list-style-type: none"> <li>• \$0 copay for QMB, QMB+, SLMB+, and FBDE members</li> <li>• \$10 copay for SLMB, QI, and QDWI members</li> </ul> |



### 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              |

**Special Supplemental Benefits**

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

**Extra Supports Wallet****Eligibility requirements:**

If you are diagnosed with one or more of the chronic conditions listed in the EOC and meet the eligibility criteria, you may be eligible for additional benefits under our plan to help manage your overall health and wellness. Enrollment in the plan does not guarantee eligibility. You will receive Special Supplemental Benefits after it is determined that you meet the eligibility requirements. However, you will not receive benefits for any time period before your eligibility was determined.

**Benefits:**

After qualifying, the \$215 monthly benefit amount in the Over-the-Counter (OTC) Wallet will change to the **Extra Supports Wallet with additional spending categories**. Qualified members can use this wallet to help pay for certain healthy foods, over-the-counter (OTC) health and wellness products, transportation, utilities, and personal care products. This will replace your OTC Wallet. You will not get any additional funds applied to your card. Approved products can be purchased in-store at participating locations including CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®.

**Important:** If you qualify, this wallet will be added to your current Extra Benefits Card.

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include but are not limited to: hypertension, hyperlipidemia, diabetes, cardiovascular disorders, and chronic lung disorders. Eligibility is determined by whether you have a chronic condition associated with the benefit(s). Standards and conditions vary for each benefit. Contact us to confirm the specific SSBCI condition requirements for the benefit(s) for this plan and determine your eligibility.

## Summary of Medicaid Benefits

**Here's a quick look at what's covered by Aetna Medicare Dual Select (HMO D-SNP) and your state Medicaid program.**

Depending on your Medicaid eligibility level, your Aetna DSNP plan may cover the additional Medicaid services listed below not otherwise covered under Medicare. Prior authorization may be required for each of the services listed below and is the responsibility of your provider.

| Services that are covered for you                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | What you must pay when you get these services in-network                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Allergy Services</li> <li>• Ambulance Transportation Services</li> <li>• Ambulatory Surgical Center (ASC) Services</li> <li>• Anesthesia Services</li> <li>• Assistive Care Services</li> <li>• Behavioral Health Analysis Services</li> <li>• Behavioral Health Assessment Services</li> <li>• Behavioral Health Community Support Services</li> <li>• Behavioral Health Intervention Services</li> <li>• Behavioral Health Medication Management Services</li> <li>• Behavioral Health Overlay Services</li> <li>• Behavioral Health Therapy Services</li> <li>• Cardiovascular Services</li> <li>• Chiropractic Services</li> <li>• Community Behavioral Health Services</li> <li>• Dental Services</li> <li>• Dialysis Services</li> <li>• Durable Medical Equipment (DME) and Medical Supply Services: Specialized</li> <li>• Durable Medical Equipment (DME) and Medical Supply Services: Respiratory</li> <li>• Durable Medical Equipment (DME) and Medical Supply Services: Wheelchairs, Hospital Beds, and Ambulatory Aids</li> <li>• Durable Medical Equipment (DME) and Medical Supply Services: Continence, Ostomy, and Wound Care</li> <li>• Durable Medical Equipment (DME) and Medical Supply Services: Enteral and Parenteral Nutritional</li> <li>• Emergency Transportation Services</li> <li>• Evaluation Management Services</li> <li>• Gastrointestinal Services</li> </ul> | <p>If you are eligible for full Medicaid, there is no coinsurance, copayment, or deductible for any of the services listed to the left.</p> |

| Services that are covered for you                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | What you must pay when you get these services in-network |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Genitourinary Services</li> <li>• Hearing Services</li> <li>• Home Health Services</li> <li>• Inpatient Hospital Services</li> <li>• Integumentary Services</li> <li>• Lab Services</li> <li>• Medical Foster Care Services</li> <li>• Medical Massage Therapy</li> <li>• Mental Health Targeted Case Management</li> <li>• Neurology Services</li> <li>• Non-Emergency Transportation Services</li> <li>• Nursing Facility Services</li> <li>• Occupational Therapy Services</li> <li>• Oral and Maxillofacial Surgery Services</li> <li>• Orthopedic Services</li> <li>• Outpatient Hospital Services</li> <li>• Pain Management Services</li> <li>• Personal Care Services</li> <li>• Physical Therapy Services</li> <li>• Podiatry Services</li> <li>• Prescribed Drug Services</li> <li>• Private Duty Nursing</li> <li>• Radiology and Nuclear Medicine Services</li> <li>• Reproductive Services</li> <li>• Respiratory System Services</li> <li>• Respiratory Therapy Services</li> <li>• Services Provided at a County Health Department and/or Federally Qualified Health Center and/or Rural Health Clinic</li> <li>• Skilled Nursing Facility (SNF) Care</li> <li>• Specialized Therapeutic Services</li> <li>• Speech Language Pathology</li> <li>• Statewide Inpatient Psychiatric Program</li> <li>• Therapeutic Group Services</li> <li>• Transplant Services</li> <li>• Visual Aid Services</li> <li>• Visual Care Services</li> </ul> |                                                          |

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.

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 [1-844-498-1860](tel:1-844-498-1860) (TTY: [711](tel:1-844-498-1860)) 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.

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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](tel:1-800-633-4227)) (TTY users should call [1-877-486-2048](tel: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](tel:1-833-859-6031) (TTY: [711](tel:1-833-859-6031)). 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) or call [1-833-859-6031](tel:1-833-859-6031) (TTY: [711](tel:1-833-859-6031)) 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, 2027.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ 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.

## Notice of Availability (NOA)

### TTY: [711](tel:711)

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

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(Vietnamese)

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