Aetna Medicare Advantra Dual (HMO D-SNP)
H3959 - 036

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 1-866-409-1221 (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/H3959-036** where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

2026-H3959.036.1

Are you eligible to enroll?

To join Aetna Medicare Advantra Dual (HMO D-SNP), you must:

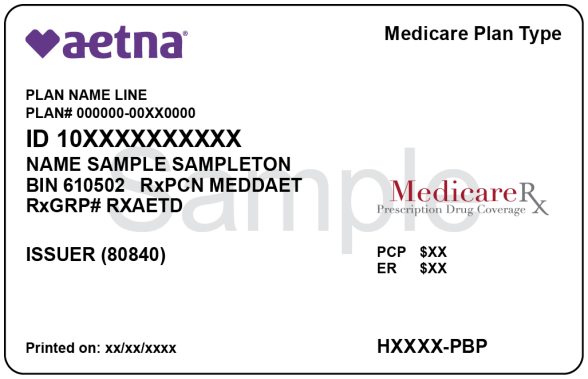
- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:
  Pennsylvania: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, York
- Be in a "Medicare Savings Program" (MSP) or qualify for State Medicaid benefits. See the table below for eligibility categories.

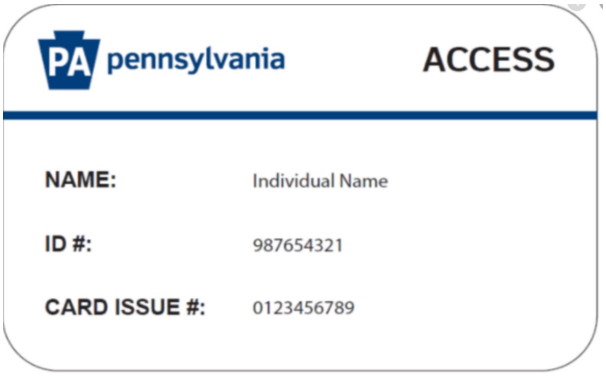
Better health is a team effort
With our Medicare Advantage Dual Eligible Special Needs Plan, or D-SNP, you'll have a care team in your corner, ready to help you reach your best health and make life easier.

- 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 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.

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





What you should know

- **Plan type:** Aetna Medicare Advantra Dual (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.
- **Referrals:** Aetna Medicare Advantra Dual (HMO D-SNP) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your 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/H3959-036**. 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
Plan deductible	$0
MOOP	$9,250 So long as Medicaid continues to pay your Medicare deductible, coinsurance, and copayments, you will not have a maximum out-of-pocket responsibility.

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	$0 copay The plan covers 90 days each benefit period and up to 60 lifetime reserve days. Lifetime reserve days can only be used once.
Outpatient hospital observation services	$0 copay
Outpatient hospital	$0 copay
Ambulatory surgical center	$0 copay

Primary Care Provider (PCP) and specialist visits

Benefit	Your costs in our plan
PCP	$0 copay
Specialist	$0 copay

Preventive, emergency and urgent care

Benefit	Your costs in our plan
Preventive care	$0 copay For a full list of preventive services available, see the EOC.
Emergency and urgent care (inside the U.S.)	$0 copay for emergency care $0 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	$0 copay for emergency care $0 copay for urgent care $0 copay for ambulance Maximum coverage: $250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency 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 costs in our plan
Diagnostic tests and procedures	$0 copay
Lab services	$0 copay
Diagnostic radiology services, such as CT/CAT scan and MRI	$0 copay
Outpatient x-rays	$0 copay

Hearing services

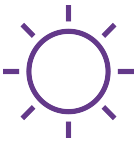
Benefit	Your costs in our plan
Diagnostic hearing exam	$0 copay
Routine hearing exam	$0 copay You get one routine hearing exam every year with a provider in the NationsHearing® network.
Hearing aids	You get an annual benefit amount (allowance) of $500 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through a NationsHearing network provider.

Dental services

Benefit	Your costs in our plan
Dental services (non-Medicare covered)	$0 copay for covered services You get an annual benefit amount (allowance) of $2,500 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, x-rays, cleanings, fillings, extractions, and more. This benefit uses the Aetna Dental PPO Network, which is different from your medical network, for covered services. If you choose a provider outside of the Aetna Dental PPO Network, services will not be covered. 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 EyeMed provider
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $450 for covered prescription eyewear. You can only use this benefit amount at an EyeMed provider. 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 costs in our plan
Inpatient psychiatric hospital stay	$0 copay Our plan covers up to 190 days per benefit period.
Outpatient mental health therapy	$0 copay for individual sessions $0 copay for group sessions
Outpatient psychiatric therapy	$0 copay for individual sessions $0 copay for group sessions

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 costs in our plan
SNF care	$0 copay Our plan covers up to 100 days per benefit period.
Physical and speech therapy	$0 copay
Occupational therapy	$0 copay

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 (ground or air, one-way trip)	$0 copay
Routine, non-emergency transportation	$0 copay You get up to 24 one-way trips every year to and from plan-approved locations (up to 80 miles each trip). Examples of plan-approved locations include medical offices and urgent care centers. We have teamed up with MTM Health to provide this benefit.

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	$0 copay
Part B Insulin	$0 copay
Other Part B drugs	$0 copay

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 Retail	Standard Mail	Long-Term Care (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 Retail	Standard 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	You get a $245 monthly benefit amount (allowance) on the Aetna Medicare Extra Benefits Card. 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®. **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 costs in our plan
Acupuncture	$0 copay for Medicare-covered acupuncture visits Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.
Chiropractic services	$0 copay for Medicare-covered chiropractic visits 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 costs in our plan
Diabetic supplies	$0 copay

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 costs in our plan
Foot exams and treatment	$0 copay for Medicare-covered and non-Medicare covered podiatry visits For non-Medicare covered services, we cover up to six visits every year.

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 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 14 freshly prepared meals for a 7-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 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 copay
Prosthetics, such as braces and artificial limbs	$0 copay
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	$0 copay

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 $245 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-Covered Benefits

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

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

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

Current Pennsylvania Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package*	
Services	**Adult Benefit Package**
Dental Care Services	Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation. **Key Limitations:** Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime. Denture relines - either full or partial, limited to 1 arch every 2 calendar years. Oral exams - 1 per 180 days Dental prophylaxis – 1 per 180 days Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years. Crowns, Periodontics and Endodontics only via approved benefit limit exception.
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	

Current Pennsylvania Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package*	
Services	**Adult Benefit Package**
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug and Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management – other than Behavioral Health	Limited to individuals identified in the target group (No limits).
Targeted Case Management – Behavioral Health Only	Limited to individuals with Serious Mental Illness (SMI) only (No limits).
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	
Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services.	Unlimited for first 28 days; limited to 15 days every month thereafter.
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits).
Durable Medical Equipment	No limits

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

Current Pennsylvania Medicaid State Plan Benefits and Home and Community Based Services	
Adult Benefit Package*	
Services	**Adult Benefit Package**

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

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

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

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

Home and Community-Based Services (HCBS)	
Services	**Limits**
	wipes and barrier cream) Items covered under third party payer liability Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability Food, food supplements, food substitutes (including formulas), and thickening agents Eyeglasses, frames, and lenses Dentures Any item labeled as experimental that has been denied by Medicare and/or Medicaid Recreational or exercise equipment and adaptive devices for such
For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.	

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 **1-866-409-1221** (**TTY: 711**) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

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.

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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. 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.

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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)

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လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိဉ်လက်ဘူဉ်လက်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိဉ်ဖဲလံာ်တီလံာ်မီအံၤ အဖီခိဉ်န့ၣ်တက့ၢ်. (Karen)

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

ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, 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)

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

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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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