



# 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 [1-833-570-6670](tel:1-833-570-6670) (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/H5521-273](https://www.aetna.com/H5521-273) 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 Signature (PPO), you must:**

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:  
**Florida:** Martin, Palm Beach, St. Lucie

## What you should know

- **Plan type:** Aetna Medicare Signature (PPO) is a PPO plan. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care.
- **Primary Care Provider (PCP):** A PCP is important to help coordinate your care. We require you to select a PCP. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Signature (PPO) 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/H5521-273](https://www.aetna.com/Medicare/H5521-273). 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<br>You must continue to pay your Medicare Part B premium.                                                                                                                                                                                                    |
| Plan deductible      | \$0                                                                                                                                                                                                                                                              |
| MOOP                 | \$6,350 for in-network services<br>\$10,100 for in- and out-of-network services combined<br><br>Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP. |

## Medical and hospital benefits



### Hospital coverage

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

| Benefit                                  | Your in-network costs                                                    | Your out-of-network costs |
|------------------------------------------|--------------------------------------------------------------------------|---------------------------|
| Inpatient (unlimited number of days)     | \$395 per day, days 1-6; \$0 per day, days 7-90; \$0 for additional days | 50% per stay              |
| Outpatient hospital observation services | \$395 copay                                                              | 50% coinsurance           |
| Outpatient hospital                      | \$350 copay                                                              | 50% coinsurance           |
| Ambulatory surgical center               | \$300 copay                                                              | 50% coinsurance           |



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

| Benefit    | Your in-network costs | Your out-of-network costs |
|------------|-----------------------|---------------------------|
| PCP        | \$0 copay             | \$55 copay                |
| Specialist | \$75 copay            | \$100 copay               |

**Preventive, emergency and urgent care**

| <b>Benefit</b>                                                              | <b>Your in-network costs</b>                                                                                                                                                                                                        | <b>Your out-of-network costs</b>                                                           |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Preventive care                                                             | \$0 copay<br>For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.                                                                                                      | \$0 copay                                                                                  |
| Emergency and urgent care (inside the U.S.)                                 | \$130 copay for emergency care<br>\$50 copay for urgent care                                                                                                                                                                        | \$130 copay for emergency care<br>\$50 copay for urgent care                               |
| Emergency and urgent care, including emergency ambulance (outside the U.S.) | \$130 copay for emergency care<br>\$130 copay for urgent care<br>\$275 copay for ambulance<br>Maximum coverage: \$250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency ambulance) | \$130 copay for emergency care<br>\$130 copay for urgent care<br>\$275 copay for ambulance |


**Diagnostic services, labs, imaging**

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

| Benefit                                                    | Your in-network costs                                                                                                                                                                                                                                                                                                                                                      | Your out-of-network costs |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| Diagnostic tests and procedures                            | \$0 - \$100 copay<br><br>\$0 copay for services performed at a non-hospital facility<br>\$100 copay for services performed at a hospital facility<br>\$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing                                                              | 50% coinsurance           |
| Lab services                                               | \$0 - \$60 copay<br><br>\$0 copay for services performed at a non-hospital facility and for certain lab services including hemoglobin A1c, urine protein, prothrombin (protime), urine albumin, fecal immunochemical test (FIT), kidney health evaluation for members with diabetes (KED) and COVID-19 testing<br>\$60 copay for services performed at a hospital facility | 50% coinsurance           |
| Diagnostic radiology services, such as CT/CAT scan and MRI | \$0 - \$350 copay<br><br>\$0 copay for services performed at a non-hospital facility<br>\$350 copay for services performed at a hospital facility                                                                                                                                                                                                                          | 50% coinsurance           |
| Outpatient x-rays                                          | \$0 - \$50 copay<br><br>\$0 copay for services performed at a non-hospital facility<br>\$50 copay for services performed at a hospital facility                                                                                                                                                                                                                            | 50% coinsurance           |



## Hearing services

| Benefit                 | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Your out-of-network costs |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| Diagnostic hearing exam | \$75 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$100 copay               |
| Routine hearing exam    | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$100 copay               |
|                         | You get one routine hearing exam every year. You can visit a provider in the NationsHearing® network or an out-of-network provider.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                           |
| Hearing aids            | <p>Hearing aids are only covered when purchased through a NationsHearing provider.</p> <p>The copay amount is based on the level of hearing aid selected and will need to be paid at the time of purchase.</p> <ul style="list-style-type: none"> <li>• Level 1 (Standard): \$0 copay per ear, per year</li> <li>• Level 2 (Select): \$475 copay per ear, per year</li> <li>• Level 3 (Superior Plus): \$650 copay per ear, per year</li> <li>• Level 4 (Advanced): \$895 copay per ear, per year</li> <li>• Level 5 (Advanced Plus): \$1,300 copay per ear, per year</li> <li>• Level 6 (Specialty): \$1,700 copay per ear, per year</li> </ul> |                           |



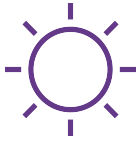
### Dental services

| Benefit                                | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Your out-of-network costs                                                                           |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Dental services (non-Medicare covered) | <p>\$0 copay for preventive services<br/>20% - 50% coinsurance for comprehensive services</p> <p>You get an annual benefit amount (allowance) of \$750 for covered comprehensive services. You are responsible for the cost of any comprehensive services over this amount.</p> <p>Covered comprehensive services include fillings, extractions, crowns, and more.</p> <p>Covered preventive services include oral exams, cleanings, and x-rays. There is no copay for these services when using an in-network provider. Covered preventive services do not count toward your annual benefit amount.</p> <p>You can use a provider in or out of the Aetna Dental PPO Network, which is different from your medical network, for covered services. However, if you use a provider outside of the network, you may be required to pay in full for services and submit a request for reimbursement. See EOC for details on exclusions and limitations.</p> | <p>50% coinsurance for preventive services<br/>50% - 70% coinsurance for comprehensive services</p> |



### Vision services

| Benefit                                           | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                             | Your out-of-network costs                                                      |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | \$100 copay                                                                    |
| Glaucoma screening                                | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         | 50% coinsurance                                                                |
| Routine eye exam (one exam every year)            | \$0 copay with an iCare provider                                                                                                                                                                                                                                                                                                                                                                                                  | \$0 copay up to \$50. You will be responsible for any billed amount over \$50. |
| Contacts and eyeglasses                           | <p>You get an annual benefit amount (allowance) of \$100 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 in-network costs                                                                                 | Your out-of-network costs                                                     |
|-------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Inpatient psychiatric hospital stay | \$390 per day, days 1-6; \$0 per day, days 7-90<br>Our plan covers up to 190 days per benefit period. | 50% per stay                                                                  |
| Outpatient mental health therapy    | \$30 copay for individual sessions<br>\$30 copay for group sessions                                   | 50% coinsurance for individual sessions<br>50% coinsurance for group sessions |
| Outpatient psychiatric therapy      | \$30 copay for individual sessions<br>\$30 copay for group sessions                                   | 50% coinsurance for individual sessions<br>50% coinsurance 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 in-network costs                                                                                    | Your out-of-network costs |
|-----------------------------|----------------------------------------------------------------------------------------------------------|---------------------------|
| SNF care                    | \$0 per day, days 1-20; \$218 per day, days 21-100<br>Our plan covers up to 100 days per benefit period. | 50% per stay              |
| Physical and speech therapy | \$40 copay                                                                                               | 50% coinsurance           |
| Occupational therapy        | \$40 copay                                                                                               | 50% coinsurance           |



### Ambulance and routine transportation

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

| Benefit                                 | Your in-network costs                                                                   | Your out-of-network costs                                                               |
|-----------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Ambulance (ground or air, one-way trip) | \$275 copay for ground ambulance services<br>20% coinsurance for air ambulance services | \$275 copay for ground ambulance services<br>20% coinsurance for air ambulance services |
| Routine, non-emergency transportation   | Not Covered                                                                             | Not Covered                                                                             |



**Medicare Part B drugs**

Medicare Part B only covers a limited number of medicines under certain conditions. These medicines are often given to you in your provider’s office. They can include things like vaccines, injections, and nebulizers, among others. They can also include medicines you take at home using special medical equipment. Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit            | Your in-network costs                                                                                                                         | Your out-of-network costs |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| Chemotherapy drugs | 0% - 20% coinsurance<br><br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | 50% coinsurance           |
| Part B Insulin     | \$35 copay                                                                                                                                    | \$35 copay                |
| Other Part B drugs | 0% - 20% coinsurance<br><br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | 50% coinsurance           |

## Medicare Part D drugs



Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes. Some drugs require **prior authorization**. This means you must get approval from us first before we'll cover them.

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

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

### Deductible phase

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

### Initial coverage phase

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

### One-month Supply

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

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

### Long-term Supply

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

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

### Out-of-pocket threshold

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

### Catastrophic coverage phase

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

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

**Insulins and vaccines**

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

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

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

## Other covered benefits



### Alternative medicine

| Benefit               | Your in-network costs                                                                                                                                                                                | Your out-of-network costs                                       |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| Acupuncture           | <p>\$75 copay for Medicare-covered acupuncture visits</p> <p>Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.</p> | <p>\$100 copay for Medicare-covered acupuncture visits</p>      |
| Chiropractic services | <p>\$15 copay for Medicare-covered chiropractic visits</p> <p>Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.</p>                  | <p>50% coinsurance for Medicare-covered chiropractic visits</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 in-network costs                                                                                                                                                                                                                                                                                                | Your out-of-network costs                                                                                                                                                                                                                                                                                            |
|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diabetic supplies | <p>0% - 20% coinsurance</p> <p>0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies</p> <p>20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization</p> | <p>0% - 20% coinsurance</p> <p>0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies</p> <p>20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization</p> |



### 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 in-network costs                           | Your out-of-network costs                        |
|--------------------------|-------------------------------------------------|--------------------------------------------------|
| Foot exams and treatment | \$55 copay for Medicare-covered podiatry visits | \$100 copay for Medicare-covered podiatry visits |



### Home care and support

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

| Benefit          | Your in-network costs | Your out-of-network costs |
|------------------|-----------------------|---------------------------|
| Home health care | \$0 copay             | 50% coinsurance           |



### Medical equipment and supplies

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

| Benefit                                                                                                                  | Your in-network costs                                                                                                                             | Your out-of-network costs |
|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| Durable medical equipment (DME), such as wheelchairs, crutches, oxygen equipment, and continuous glucose monitors (CGMs) | <p>0% - 20% coinsurance</p> <p>0% coinsurance for continuous glucose monitors</p> <p>20% coinsurance for all other Medicare-covered DME items</p> | 50% coinsurance           |
| Prosthetics, such as braces and artificial limbs                                                                         | 20% coinsurance                                                                                                                                   | 50% coinsurance           |



### Resources For Living®

#### Benefit

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



### Substance use disorder services

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

| Benefit                                    | Your in-network costs                                               | Your out-of-network costs                                                     |
|--------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Outpatient substance use disorder services | \$30 copay for individual sessions<br>\$30 copay for group sessions | 50% coinsurance for individual sessions<br>50% coinsurance for group sessions |



### Visitor/travel benefit

Plan rules continue to apply. You will need to choose a PCP where you are receiving care. **Prior authorizations** are required for certain services.

#### Benefit

|                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Visitor/travel program: Explorer | <p>Allows you to remain in your plan for up to 12 months when you are outside our plan's service area.</p> <p>While traveling within the United States, you can see an Aetna Medicare participating provider and pay in-network cost shares. Not all providers participate in the multi-state network. In most cases, when you receive non-urgent/non-emergency care from an out-of-network provider, your share of the costs for your covered services may be higher. You must select a PCP in the visitor/travel area in order for services to be covered. Contact us for help finding a participating provider in the area you're traveling to.</p> |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



### 24-Hour Nurse Line

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

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

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

See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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

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

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

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

For mail order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call **1-833-570-6670 (TTY: 711)** 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

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

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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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**) (TTY users should call **1-877-486-2048**), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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

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# Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [1-833-859-6031](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/medicare) 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.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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## Notice of Availability (NOA)

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

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