



Summary of Benefits 2027

January 1, 2027 through December 31, 2027

This is a summary of your plan's costs and coverage. For a complete list of what we cover and any limitations, review the plan's *Evidence of Coverage* (EOC) at [AetnaMedicare.com/H1609-090](https://www.aetna.com/H1609-090) or call us to request a copy.

Your questions are important to us, and we're here to help

If you are an Aetna plan member, 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 are not yet an Aetna plan member, call:

[1-844-509-6254](tel:1-844-509-6254) (TTY: [711](tel:1-844-509-6254))
October 1–March 31: 8 AM to 8 PM, 7 days a week
April 1–September 30: 8 AM to 8 PM, Monday–Friday

An Aetna team member will answer your call.

2027-H1609.090.1

About this plan

Aetna Medicare Full Dual Select (HMO D-SNP) is a D-SNP, or Dual Eligible Special Needs plan. This is a Medicare Advantage plan that covers prescription drugs. 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. Please take a moment to review the following important information:

- **Primary care provider (PCP):** We require that you select a network PCP to help coordinate your care. When you enroll, we'll ask which PCP you have chosen. If you don't choose a PCP, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal. Be sure to show your Aetna® member ID card when you visit a provider or pharmacy.
- **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/H1609-090](https://www.aetna.com/H1609-090). 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.

Better health is a team effort

With our Medicare Advantage Dual Eligible Special Needs Plan (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.

Are you eligible to enroll?

To join **Aetna Medicare Full Dual Select (HMO D-SNP)**, you'll need to meet the following criteria:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Be in a "Medicare Savings Program" (MSP) or qualify for state Medicaid benefits. See the table below for eligibility categories.
- Live in the plan's service area, which includes the following county:
Florida: Palm Beach

Medicare Savings Program

Eligibility category	What it covers
Qualified Medicare Beneficiary Plus (QMB+)	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.

Eligibility category	What it covers
Specified Low-Income Medicare Beneficiary Plus (SLMB+)	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.

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

Understanding out-of-pocket costs

- **Plan premium:** the amount you pay monthly to keep your health insurance active.
- **Deductible:** the amount you must pay for health care before our plan pays.
- **Maximum out-of-pocket:** the most you'll pay out of pocket in a plan year for covered care.

Out-of-pocket costs	
Monthly plan premium	\$0
Plan deductible	\$0
MOOP	\$9,850
	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 (unlimited number of days)	\$0 copay
Outpatient hospital observation services	\$0 copay
Outpatient hospital	\$0 copay
Ambulatory surgical center	\$0 copay

Primary care provider (PCP) and specialist services

Benefit	Your costs in our plan
PCP	\$0 copay

Benefit	Your costs in our plan
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. This is the most we will pay for the combined cost of emergency care, urgent care, and emergency ambulance services received outside of the U.S.

Diagnostic services, labs, and 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
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 \$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 an authorized 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 You get an annual benefit amount (allowance) of \$3,000 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, cleanings, fillings, extractions, crowns, dentures, and more. We have teamed up with Liberty Dental to provide your dental coverage. This benefit uses the Liberty Dental network, which is different from your medical network, for covered services. If you choose a provider outside of the Liberty Dental network, services will not be covered. See EOC for details on exclusions and limitations.

Vision services

Benefit	Your 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 network optometrist
Contacts and eyeglasses	With this plan, each calendar year you can get one of the following through an iCare network optometrist: • Eyeglasses: Up to three pairs every year from the iCare "covered in full" eyewear collection at no cost OR • An annual benefit amount (allowance) of \$400 for prescription eyewear including contact lenses or eyeglasses (including lenses and frames), and • Upgrades: including UV protection and scratch coating We have teamed up with iCare Health Solutions to provide this benefit.

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

Benefit	Your costs in our plan
	There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.
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. 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	\$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. 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 unlimited 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 our authorized vendor 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 preventive 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, \$1.65, or \$5.80. For all other covered drugs: \$0, \$5.00, or \$14.40.

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 \$700. 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 30-day	Standard Mail 30-day	Long-Term Care (LTC) 31-day
Tier 1: Preferred Generic	\$0	\$0	\$0
Tier 2: Generic	\$0	\$0	\$0
Tier 3: Preferred Brand	9%	9%	9%
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 100-day	Standard Mail 100-day
Tier 1: Preferred Generic	\$0	\$0
Tier 2: Generic	\$0	\$0

	Standard Retail	Standard Mail
	100-day	100-day
Tier 3: Preferred Brand	9%	9%
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	\$2,400 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	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. Part D preventive 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 Part D 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. Qualifying members may be eligible for additional spending categories. See the Special Supplemental Benefits chart for more details.

Benefit	
Over-the-Counter (OTC) Wallet	You get a \$367 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 authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at CVS.com/Aetna, or shop by phone.

Benefit	
	Important: • If you received an Aetna Medicare Extra Benefits Card in 2026 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2027 plan year. • If you are a new member or were not enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026, you should get a new card before your plan begins. • If you enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026 and 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 \$0 copay for non-Medicare covered chiropractic visits 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.

Diabetic supplies

Benefit	Your costs in our plan
Diabetic supplies	\$0 copay for Medicare-covered diabetic supplies We exclusively cover Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGMs) and test strips as preferred supplies. \$0 copay for Medicare-covered continuous glucose monitors (CGMs)

Fitness benefit

Benefit	Your costs in our plan
Basic SilverSneakers® fitness membership	\$0 copay

Benefit	Your costs in our plan
	You get a basic membership to any authorized participating SilverSneakers® fitness facility. Additionally, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers.

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 twenty four 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, such as part-time skilled nursing and health aide services, and physical therapy	\$0 copay for Medicare-covered home health care services Non-Medicare covered home health care services are not covered.
Meal benefit (post-discharge)	\$0 copay for the meal benefit when you use our authorized vendor, NationsMarket™ 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 our authorized vendor NationsMarket™ to provide this benefit.
Personal emergency response system	\$0 copay Our plan covers a medical alert response system through our authorized vendor LifeStation to provide you with 24/7 access to help in the event of a fall or an emergency. LifeStation is our authorized vendor for this benefit. Members access this benefit through Aetna care management.

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, and oxygen equipment	\$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	Your costs in our plan
Resources For Living®	Resources For Living® helps connect you with local community services such as caregiver support, meal and in-home care services, volunteer activities, and transportation. These services are not the same as the benefits covered by your Aetna plan, and Aetna does not provide the services. If you use services that have costs, you'll need to pay for those. Resources For Living® also offers one-on-one coaching at no added cost to support your personal goals, such as improving physical wellness, building social connections, or focusing on personal growth.

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 for individual sessions \$0 copay for group sessions

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

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 all other 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 meeting all eligibility requirements, the \$367 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 authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at CVS.com/Aetna, or shop by phone. Important: If you qualify, this wallet will be added to your current Aetna® Medicare 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) and you meet all other criteria. Even if you have a listed chronic condition, you may not necessarily receive the benefit because other eligibility and coverage criteria may apply. 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.

In-Home Support Personal Care Services

Eligibility requirements	If your care manager or physician assesses that you have an inability (such as vision impairments, mobility problems, or other musculoskeletal challenges) to complete and need assistance with more than one activity of daily living (ADL), and you meet the eligibility criteria, you may be eligible for this benefit under our plan. Enrollment in this plan does not guarantee eligibility. If you qualify, a care manager will work with our authorized vendor, The Helper Bees®, to set up the services.
Benefits	The in-home support personal care services benefit provides up to 60 hours of in-home personal care services per year. This benefit can provide help with meal preparation, light housekeeping, medication reminders, and more.

Recovery at Home Program

Eligibility requirements	If you have an acute inpatient facility stay due to a qualifying diagnosis, and an Aetna care manager determines you have an inability to complete and need assistance with at least one activity of daily living (ADL) and/or instrumental activity of daily living (IADL), you may be eligible for in-home support services offered through this program under our plan. Enrollment in this plan does not guarantee eligibility. If you qualify, a care manager will work with our authorized vendor, The Helper Bees®, to set up the in-home support services that must be used within 30 days of discharge and expire after the 30-day period ends.
Benefits	The Recovery at Home Program provides in-home support services up to 80 hours once per qualifying diagnosis, per year. The in-home support services can provide help with meal preparation, light housekeeping, medication reminders, and more.

Summary of Medicaid benefits

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

Your Aetna DSNP may cover the additional Medicaid services 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
• Allergy Services • Ambulance Transportation Services • Ambulatory Surgical Center (ASC) Services • Anesthesia Services • Assistive Care Services • Behavioral Health Analysis Services • Behavioral Health Assessment Services • Behavioral Health Community Support Services • Behavioral Health Intervention Services • Behavioral Health Medication Management Services • Behavioral Health Overlay Services • Behavioral Health Therapy Services • Cardiovascular Services • Chiropractic Services • Community Behavioral Health Services • Dental Services • Dialysis Services • Durable Medical Equipment (DME) and Medical Supply Services: Specialized	If you are eligible for full Medicaid, there is no coinsurance, copayment, or deductible for any of the services listed to the left.

Services that are covered for you	What you must pay when you get these services in-network
• Durable Medical Equipment (DME) and Medical Supply Services: Respiratory • Durable Medical Equipment (DME) and Medical Supply Services: Wheelchairs, Hospital Beds, and Ambulatory Aids • Durable Medical Equipment (DME) and Medical Supply Services: Continence, Ostomy, and Wound Care • Durable Medical Equipment (DME) and Medical Supply Services: Enteral and Parenteral Nutritional • Emergency Transportation Services • Evaluation Management Services • Gastrointestinal Services • Genitourinary Services • Hearing Services • Home Health Services • Inpatient Hospital Services • Integumentary Services • Lab Services • Medical Foster Care Services • Medical Massage Therapy • Mental Health Targeted Case Management • Neurology Services • Non-Emergency Transportation Services • Nursing Facility Services • Occupational Therapy Services • Oral and Maxillofacial Surgery Services • Orthopedic Services • Outpatient Hospital Services • Pain Management Services • Personal Care Services • Physical Therapy Services • Podiatry Services • Prescribed Drug Services • Private Duty Nursing • Radiology and Nuclear Medicine Services • Reproductive Services • Respiratory System Services • Respiratory Therapy Services • Services Provided at a County Health Department and/or Federally Qualified Health Center and/or Rural Health Clinic • Skilled Nursing Facility (SNF) Care • Specialized Therapeutic Services • Speech Language Pathology	

Services that are covered for you	What you must pay when you get these services in-network
• Statewide Inpatient Psychiatric Program • Therapeutic Group Services • Transplant Services • Visual Aid Services • Visual Care Services	

Disclaimers

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

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

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

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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.

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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 **1-844-509-6254** (TTY: **711**). From October 1 to March 31, you can call us 7 days a week from 8 AM to 8 PM local time. From April 1 to September 30, we're here Monday through Friday from 8 AM to 8 PM local time.

Understanding the benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [AetnaMedicare.com](https://www.aetna.com/medicare) or call **1-844-509-6254** (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, 2028.
- ☐ 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)

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

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Inā ake ‘oe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ‘oe 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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무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພື່ອ ຄົ້ນຄວາມການ ບໍລິການພາສາໂດຍ ບໍ່ສະຍາ ກໍ່ໃຊ້ຈ່າຍໃດໆ, ໃຫ້ ໂທຫາ ບົດໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

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(Vietnamese)

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