



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/H3288-053](https://www.aetna.com/H3288-053) 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:

[1-866-409-1221](tel:1-866-409-1221) (TTY: [711](tel:1-866-409-1221))

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.

About this plan

Aetna Medicare Dual Care (PPO D-SNP) is a D-SNP, or Dual Eligible Special Needs 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. 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 and, if you are supplied with one, your state Medicaid ID card when you visit a provider or pharmacy.
- **Referrals:** Aetna Medicare Dual Care (PPO 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 PCP 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/H3288-053](https://www.aetna.com/H3288-053). 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 Dual Care (PPO 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 counties:
Oklahoma: Adair, Atoka, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Cleveland, Coal, Cotton, Craig, Creek, Custer, Delaware, Garfield, Garvin, Grady, Grant, Haskell, Hughes, Jefferson, Johnston, Kay, Kingfisher, Le Flore, Lincoln, Logan, Love, Major, Marshall, Mayes, McClain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Seminole, Sequoyah, Stephens, Tulsa, Wagoner

Medicare Savings Program

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+)	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+)	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.

IMPORTANT: If you receive assistance from Medicaid you may pay less than the cost-sharing amounts listed in this document. If your category of Medicaid eligibility changes, your cost share may increase or decrease. Please refer to the *Evidence of Coverage* for additional benefit details.

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 - \$283 The annual plan deductible applies to certain out-of-network services. Your deductible is what you'll pay before we begin to pay for services. These are 2026 cost-sharing amounts and may change for 2027. Aetna Medicare Dual Care (PPO D-SNP) will provide updated rates as soon as they are released.
MOOP	\$9,850 for in-network services \$14,800 for in- and out-of-network services combined Depending on your Medicaid "Medicare Savings Program" eligibility category, Medicaid may pay your cost shares until you reach the maximum out-of-pocket. Once you reach the limit, we will pay the full cost for plan-covered services for the rest of the year.

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 in-network costs	Your out-of-network costs
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.	\$0 copay - \$2,240 per stay after your plan deductible is met
Outpatient hospital observation services	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Outpatient hospital	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Ambulatory surgical center	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met

Primary care provider (PCP) and specialist services

Benefit	Your in-network costs	Your out-of-network costs
PCP	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Specialist	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met

Preventive, emergency, and urgent care

Benefit	Your in-network costs	Your out-of-network costs
Preventive care	\$0 copay For a full list of preventive services available, see the EOC.	\$0 copay
Emergency and urgent care (inside the U.S.)	\$0 copay for emergency care \$0 copay for urgent care	\$0 - \$115 copay for emergency care \$0 - \$40 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.	\$0 copay for emergency care \$0 copay for urgent care \$0 copay for ambulance

Diagnostic services, labs, and 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 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Lab services	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Diagnostic radiology services, such as CT/CAT scan and MRI	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Outpatient x-rays	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met

Hearing services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic hearing exam	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Routine hearing exam	\$0 copay	\$0 copay - \$0 copay after your plan deductible is met
	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	You get an annual benefit amount (allowance) of \$2,000 per ear. If the cost is over the benefit amount, you pay the difference. When you use our authorized vendor, NationsHearing®, your benefit amount will be applied at the time of purchase. If you use an unauthorized vendor, you will have to pay upfront and request reimbursement from NationsHearing.	If you do not use our authorized vendor, NationsHearing, for this benefit, you will have to pay out of pocket at the time of purchase and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount.

Dental services

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

Benefit	Your in-network costs	Your out-of-network costs
Dental services (non-Medicare covered)	\$0 copay for covered services	\$0 copay or 30%-70% coinsurance for covered services

Benefit	Your in-network costs	Your out-of-network costs
	You get an annual benefit amount (allowance) of \$2,000 for covered comprehensive services. You are responsible for the cost of any comprehensive services over this amount. Covered comprehensive services include fillings, extractions, crowns, and more. Covered preventive services include oral exams, cleanings, and x-rays. There is no copay for these services and they do not count toward your annual benefit amount. We have teamed up with Liberty Dental to provide your dental coverage. You can use a provider in or out of the Liberty Dental network, which is different from your medical network, for covered services. However, if you use a provider outside of the network, you may pay more for covered services.	

Vision services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic eye exam (includes diabetic eye exams)	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Glaucoma screening	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Routine eye exam (one exam every year)	\$0 copay with an EyeMed network provider	The out-of-network routine eye exam is covered up to \$50. You may be required to pay up front and submit a reimbursement request to EyeMed. You will be responsible for any billed amount over \$50.
Contacts and eyeglasses	You get an annual benefit amount (allowance) of \$200 for covered prescription eyewear. We have teamed up with EyeMed to provide this benefit. When you use an EyeMed network 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. If you use a provider outside of the EyeMed network, you may be required to pay up front and request reimbursement up to your benefit amount. You may also be responsible for additional costs. See EOC for details.	

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	\$0 copay	\$0 copay - \$2,090 per stay after your plan deductible is met

Benefit	Your in-network costs	Your out-of-network costs
	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	\$0 copay - 30% coinsurance for individual sessions after your plan deductible is met \$0 copay - 30% coinsurance for group sessions after your plan deductible is met
Outpatient psychiatric therapy	\$0 copay for individual sessions \$0 copay for group sessions	\$0 copay - 30% coinsurance for individual sessions after your plan deductible is met \$0 copay - 30% coinsurance for group sessions after your plan deductible is met

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 copay Our plan covers up to 100 days per benefit period.	\$0 copay - \$0 per day, days 1-20; \$221 per day, days 21-100 after your plan deductible is met
Physical and speech therapy	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met
Occupational therapy	\$0 copay	\$0 copay - 30% coinsurance after your plan deductible is met

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 in-network costs	Your out-of-network costs
Ambulance (ground or air, one-way trip)	\$0 copay	\$0 copay - 20% coinsurance after your plan deductible is met
Routine, non-emergency transportation	\$0 copay for each transportation service when you use our authorized vendor, MTM Health.	If you do not use our authorized vendor MTM Health for this benefit, you will have to pay out of pocket at the time of purchase and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount.

Benefit	Your in-network costs	Your out-of-network costs
	You get up to 24 one-way trips every year to and from plan-approved locations (up to 100 miles each trip). Examples of plan-approved locations include medical offices and urgent care centers. 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 in-network costs	Your out-of-network costs
Chemotherapy drugs	\$0 copay	\$0 copay - 20% coinsurance after your plan deductible is met
Part B Insulin	\$0 copay	\$0 - \$35 copay after your plan deductible is met
Other Part B drugs	\$0 copay	\$0 copay - 20% coinsurance after your plan deductible is met

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	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	25%	25%	25%
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	25%	25%
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 \$135 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. 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 in-network costs	Your out-of-network costs
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.	\$0 copay - 30% coinsurance for Medicare-covered acupuncture visits after your plan deductible is met
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.	\$0 copay - 30% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met

Diabetic supplies

Benefit	Your in-network costs	Your out-of-network costs
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)	\$0 copay or 0% - 20% coinsurance for Medicare-covered diabetic supplies after your plan deductible is met • \$0 copay for some members, based on your level of Medicaid eligibility • 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGM) and medical diabetic supplies • 20% coinsurance for blood glucose meters (BGM) and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization We exclusively cover Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGMs) and test strips as preferred supplies. 20% coinsurance for Medicare-covered continuous glucose monitors (CGMs) after your plan deductible is met

Fitness benefit

Benefit	Your in-network costs	Your out-of-network costs
Basic SilverSneakers® fitness membership	\$0 copay for the fitness benefit when you use our authorized vendor, SilverSneakers 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.	If you do not use our authorized vendor, SilverSneakers, for this benefit, you will have to pay out of pocket at the time of service for an equivalent membership and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount.

Foot care (podiatry services)

Benefit	Your in-network costs	Your out-of-network costs
Foot exams and treatment	\$0 copay for Medicare-covered and non-Medicare covered podiatry visits For non-Medicare covered services, we cover up to twelve visits every year.	\$0 copay - 20% coinsurance for Medicare-covered podiatry visits after your plan deductible is met \$0 copay - 20% coinsurance for non-Medicare podiatry visits after your plan deductible is met

Home care and support

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

Benefit	Your in-network costs	Your out-of-network costs
Home health care, 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.	\$0 - \$0 copay for Medicare-covered home health care services after your plan deductible is met
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 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 our authorized vendor NationsMarket™ to provide this benefit.	If you do not use our authorized vendor NationsMarket for this benefit, you will have to pay out of pocket at the time of purchase and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount.
Personal emergency response system	\$0 copay for the personal emergency response system. This benefit can be accessed through your care manager. We cover a personal emergency response system to provide you with access to help in the event of an emergency, 24 hours a day, 7 days a week. If you don't have a care manager, contact Member Services at the number on your member ID card for assistance.	\$0 copay for the personal emergency response system. This benefit can be accessed through your care manager.

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, and oxygen equipment	\$0 copay	\$0 copay - 20% coinsurance after your plan deductible is met
Prosthetics, such as braces and artificial limbs	\$0 copay	\$0 copay - 20% coinsurance after your plan deductible is met
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 in-network costs	Your out-of-network costs
Outpatient substance use disorder services	\$0 copay for individual sessions \$0 copay for group sessions	\$0 copay - 30% coinsurance for individual sessions after your plan deductible is met \$0 copay - 30% coinsurance for group sessions after your plan deductible is met

Visitor/traveler 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/traveler program: Explorer	This benefit allows you to remain in your plan for up to 12 months when you are outside your plan's service area. While traveling within the United States, you can see an Aetna Medicare participating provider and pay in-network cost shares. If you use an out-of-network provider while participating in the visitor/traveler program, your cost share may be higher. Not all providers participate in the multi-state network. 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.

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 \$135 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.

Aetna High Value Provider Incentive Program (HVPIP)

Eligibility requirements	A High Value primary care provider (PCP) can offer a holistic approach to managing your care. You may be eligible for the additional supplemental benefit(s) shown below if you qualify to get the Extra Supports Wallet and select a qualifying High Value PCP as your PCP of record. For more information on the program and how to qualify, see the EOC.
Benefits	If you qualify, you get: - Extra Supports High Value Provider (HVP) Wallet: \$30 monthly benefit amount (allowance) on an Extra Supports HVP Wallet loaded onto the 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.

Summary of Medicaid benefits

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

Below is a summary of your Medicaid and Aetna Medicare Dual Care (PPO D-SNP) benefits. If you qualify for Medicare and Medicaid (or "Medical Assistance"), you're "dual eligible." This means you're eligible for benefits under both the federal Medicare program and the Oklahoma Medicaid program.

What you pay for covered services may depend on your level of Medicaid eligibility. If you meet the state's requirements for full Medicaid coverage, you may also receive Medicaid services not covered by Medicare. If you have questions about your Medicaid eligibility and what benefits you're entitled to, or for a full list of your covered Medicaid benefits, just call your SoonerCare Medicaid program.

The table below gives you a summary of the benefits Medicaid covers. Aetna Medicare Dual Care (PPO D-SNP) covers the benefits we described earlier in the Medical and hospital benefits section. For each benefit listed below, you can see what Medicaid covers and what our plan covers. **Keep in mind:** Medicaid may cover additional benefits that are not listed below. There may be limits for some services. If you need a service that is only covered by Medicaid, the provider you pick needs to be enrolled with Medicaid.

Service	State Medicaid	Aetna Medicare Dual Care (PPO D-SNP)
Acupuncture	Covered with limitations	Limited (see EOC for coverage details)
Ambulance	✓	✓
Ambulatory surgical center (ASC) services	✓	✓

Service	State Medicaid	Aetna Medicare Dual Care (PPO D-SNP)
Chiropractic services	Covered with limitations	Limited (see EOC for coverage details)
Dental services	✓	✓
Diagnostic services/labs/imaging (includes diagnostic tests and procedures, labs, diagnostic radiology, and x-rays)	✓	✓
Doctor visits (primary care providers & specialists)	✓	✓
Emergency care	✓	✓
Hearing services	✓	✓
Home health care	✓	✓
Hospice	✓	Limited (see EOC for coverage details)
Inpatient hospital services	✓	✓
Long-term nursing home care (i.e., custodial nursing home care)	✓	Not Covered
Mental health services	✓	✓
Occupational therapy	✓	✓
Outpatient hospital services	✓	✓
Physical and speech therapy	✓	✓
Podiatry	Not Covered	✓
Prescription drugs	Limited (6 per month limit; up to 2 brand name)	✓
Preventive care	✓	✓
Skilled nursing facility (SNF)	✓	✓
Transportation	✓	✓
Urgently needed services	✓	✓
Vision services	Limited (eye diseases or eye injuries only)	✓

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 **1-866-409-1221 (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.

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.
- ☐ 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.
- ☐ 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](tel:711)

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