



# 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/H4523-042](https://www.aetna.com/H4523-042) 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:**

**[1-833-570-6670](tel:1-833-570-6670) (TTY: [711](tel:1-833-570-6670))**

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-H4523.042.1

# About this plan

**Aetna Medicare Signature (HMO)** is an HMO plan. This is a Medicare Advantage plan that covers prescription drugs. 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.
- **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/H4523-042](https://www.aetna.com/medicare/H4523-042). 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.

# Are you eligible to enroll?

To join **Aetna Medicare Signature (HMO)**, you'll need to meet the following criteria:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:  
**Texas:** El Paso, Hudspeth

# 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<br><br>You must continue to pay your Medicare Part B premium.                                                                                                               |
| Plan deductible      | \$0                                                                                                                                                                             |
| MOOP                 | \$7,150<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 costs in our plan                                                                                                                       |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient (unlimited number of days)     | \$395 per day, days 1-6; \$0 per day, days 7-90; \$0 for additional days                                                                     |
| Outpatient hospital observation services | \$395 copay                                                                                                                                  |
| Outpatient hospital                      | \$30 - \$350 copay<br><br>\$30 copay for outpatient hospital services other than surgery<br>\$350 copay for each outpatient hospital surgery |
| Ambulatory surgical center               | \$300 copay                                                                                                                                  |

## Primary care provider (PCP) and specialist services

| Benefit    | Your costs in our plan |
|------------|------------------------|
| PCP        | \$0 copay              |
| Specialist | \$30 copay             |

## Preventive, emergency, and urgent care

| Benefit                                                                     | Your costs in our plan                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Preventive care                                                             | \$0 copay<br><br>For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.                                                                                                                                              |
| Emergency and urgent care (inside the U.S.)                                 | \$130 copay for emergency care<br>\$40 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>\$250 copay for ambulance<br><br>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                             | \$50 copay<br><br>\$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing                     |
| Lab services                                                | \$0 copay                                                                                                                                                                                      |
| Diagnostic radiology services, such as CT/ CAT scan and MRI | \$210 copay                                                                                                                                                                                    |
| Outpatient x-rays                                           | \$0 - \$35 copay<br><br>\$0 copay for services provided by your primary care provider in their office<br>\$35 copay for services performed by a provider other than your primary care provider |

## Hearing services

| Benefit                 | Your costs in our plan                                                                                                                                                                                                                               |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic hearing exam | \$30 copay                                                                                                                                                                                                                                           |
| Routine hearing exam    | \$0 copay<br><br>You get one routine hearing exam every year with a provider in the NationsHearing® network.                                                                                                                                         |
| Hearing aids            | You get an annual benefit amount (allowance) of \$500 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through an authorized NationsHearing® network provider. |

## Dental services

| Benefit                                | Your costs in our plan                                                          |
|----------------------------------------|---------------------------------------------------------------------------------|
| Dental services (non-Medicare covered) | \$0 copay for preventive services<br>50% coinsurance for comprehensive services |

| Benefit | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|         | <p>You get an annual benefit amount (allowance) of \$1,000 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 and they do not count toward your annual benefit amount.</p> <p>This benefit uses the Aetna Dental PPO Network, which is different from your medical network, for covered services. If you choose a provider outside of the Aetna Dental PPO Network, services will not be covered.</p> <p>See EOC for details on exclusions and limitations.</p> |

## Vision services

| Benefit                                           | Your costs in our plan                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 copay                                                                                                                                                                                                                                                                                                                                                |
| Glaucoma screening                                | \$0 copay                                                                                                                                                                                                                                                                                                                                                |
| Routine eye exam (one exam every year)            | \$0 copay with an EyeMed network provider                                                                                                                                                                                                                                                                                                                |
| Contacts and eyeglasses                           | <p>You get an annual benefit amount (allowance) of \$150 for covered prescription eyewear.</p> <p>Your benefit amount can only be used to purchase eyewear through 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.</p> |

## Mental health services

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

| Benefit                             | Your costs in our plan                                                                                                                            |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient psychiatric hospital stay | <p>\$300 per day, days 1-6; \$0 per day, days 7-90</p> <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.</p> |
| Outpatient mental health therapy    | <p>\$35 copay for individual sessions</p> <p>\$35 copay for group sessions</p>                                                                    |
| Outpatient psychiatric therapy      | <p>\$35 copay for individual sessions</p> <p>\$35 copay for group sessions</p>                                                                    |

## 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 per day, days 1-20; \$210 per day, days 21-100<br>Our plan covers up to 100 days per benefit period. |
| Physical and speech therapy | \$35 copay                                                                                               |
| Occupational therapy        | \$35 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<br>(ground or air, one-way trip) | \$250 copay for ground ambulance services<br>20% coinsurance for air ambulance services |
| Routine, non-emergency transportation      | 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 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 | 20% coinsurance        |
| Part B Insulin     | \$35 copay             |
| Other Part B drugs | 20% 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).

|                         |                                                                                                                                       |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible phase</b> | You'll pay the plan's negotiated drug cost up to the deductible limit of \$300. 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<br>30-day | Standard Retail<br>30-day | Preferred Mail<br>30-day | Standard Mail<br>30-day | Long-Term Care (LTC)<br>31-day |
|----------------------------|----------------------------|---------------------------|--------------------------|-------------------------|--------------------------------|
| Tier 1: Preferred Generic  | \$0                        | \$5                       | \$0                      | \$5                     | \$5                            |
| Tier 2: Generic            | \$5                        | \$12                      | \$5                      | \$12                    | \$12                           |
| Tier 3: Preferred Brand    | 18%                        | 18%                       | 18%                      | 18%                     | 18%                            |
| Tier 4: Non-Preferred Drug | 30%                        | 30%                       | 30%                      | 30%                     | 30%                            |
| Tier 5: Specialty          | 30%                        | 30%                       | 30%                      | 30%                     | 30%                            |

### Long-term Supply

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

|                            | Preferred Retail<br>100-day                              | Standard Retail<br>100-day | Preferred Mail<br>100-day | Standard Mail<br>100-day |
|----------------------------|----------------------------------------------------------|----------------------------|---------------------------|--------------------------|
| Tier 1: Preferred Generic  | \$0                                                      | \$15                       | \$0                       | \$15                     |
| Tier 2: Generic            | \$15                                                     | \$36                       | \$5                       | \$36                     |
| Tier 3: Preferred Brand    | 18%                                                      | 18%                        | 18%                       | 18%                      |
| Tier 4: Non-Preferred Drug | 30%                                                      | 30%                        | 30%                       | 30%                      |
| Tier 5: Specialty          | A long-term supply is not available for drugs on Tier 5. |                            |                           |                          |

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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.<br><br>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.<br><br>Part D preventive vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible.<br><br>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.

| Benefit                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CVS Over-the-Counter (OTC) Wallet | <p>You get a \$30 quarterly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card.</p> <p>You can use your CVS 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 CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at <a href="https://www.CVS.com/Aetna">CVS.com/Aetna</a>, or shop by phone.</p> <p>Important:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li><li>• 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.</li></ul> |

## Alternative medicine

| Benefit               | Your costs in our plan                                                                                                                                                                               |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Acupuncture           | <p>\$30 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> |
| 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>                  |

## Diabetic supplies

| Benefit           | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diabetic supplies | <p>0% - 20% coinsurance for Medicare-covered diabetic supplies</p> <ul style="list-style-type: none"><li>• 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGM) and medical diabetic supplies</li><li>• 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</li></ul> <p>We exclusively cover Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGMs) and test strips as preferred supplies.</p> <p>0% coinsurance for Medicare-covered continuous glucose monitors (CGMs)</p> |

## Fitness benefit

| Benefit                                  | Your costs in our plan                                                                                                                                                                                                                                   |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Basic SilverSneakers® fitness membership | <p>\$0 copay</p> <p>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.</p> |

## Foot care (podiatry services)

You may have to get a referral from your PCP before you can receive these services.

| Benefit                  | Your costs in our plan                                                                                                |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Foot exams and treatment | <p>\$30 copay for Medicare-covered podiatry visits</p> <p>Non-Medicare covered podiatry services are not covered.</p> |

## Home care and support

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

| Benefit                                                                                            | Your costs in our plan                                                                                                                 |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Home health care, such as part-time skilled nursing and health aide services, and physical therapy | <p>\$0 copay for Medicare-covered home health care services</p> <p>Non-Medicare covered home health care services are not covered.</p> |

## 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 | 20% coinsurance        |
| Prosthetics, such as braces and artificial limbs                                     | 20% coinsurance        |

## 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 | \$35 copay for individual sessions<br>\$35 copay for group sessions |

## Visitor/traveler benefit

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

| Benefit                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Visitor/traveler program:<br>Travel Advantage | 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 (except California and Puerto Rico), 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, care you receive from an out-of-network provider will not be covered. PCP and referral rules still apply. You must select a PCP in the visitor/traveler 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.

| Aetna Cancer Care Support Program |                                                                                                                                                                            |
|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Eligibility requirements          | If you have been diagnosed with cancer by a medical professional and are receiving active cancer treatment, you may be eligible for the Aetna Cancer Care Support Program. |
| Benefits                          | If you qualify, you can get certain in-person and/or telehealth oncologist/specialist office visits with an Aetna-designated provider for \$0.                             |

## 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.

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in: Rural Nebraska, Rural North Dakota, Suburban West Virginia, Urban Kansas, and Urban Missouri. 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 **1-844-509-6254** (TTY: **711**) or consult the online pharmacy directory at [AetnaMedicare.com/findpharmacy](https://www.aetna.com/medicare/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.

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.
- ☐ 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).

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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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Pour accéder gratuitement aux services linguistiques, appelez le numéro indiqué sur ce document. (French)

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Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer in diesem Dokument an. (German)

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