



# 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/H4523-050](https://www.aetna.com/H4523-050) 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:

**1-833-595-1008 (TTY: 711)**  
8 AM to 8 PM, 7 days a week

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

**1-833-771-2456 (TTY: 711)**  
October 1–March 31: 8 AM to 8 PM, 7 days a week  
April 1–September 30: 8 AM to 8 PM, Monday–Friday

An Aetna team member will answer your call.

2027-H4523.050.1

# About this plan

**Aetna Medicare Chronic Care Total (HMO C-SNP)** is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. 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.
- **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:** Aetna Medicare Chronic Care Total (HMO C-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/H4523-050](https://www.aetna.com/H4523-050). 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 Chronic Care Total (HMO C-SNP)**, you'll need to meet the following criteria:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Must have one of the following qualifying conditions verified by a physician: diabetes mellitus, chronic heart failure, and/or cardiovascular disorders.
- Live in the plan's service area, which includes the following county:  
**Texas:** Hidalgo

# 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                                                    |
|                      | You must continue to pay your Medicare Part B premium. |

| Out-of-pocket costs |                                                                                                                                                                                                                                                                        |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan deductible     | <p>\$283</p> <p>Your deductible is what you'll pay before we begin to pay for services.</p> <p>These are 2026 cost-sharing amounts and may change for 2027. Aetna Medicare Chronic Care Total (HMO C-SNP) will provide updated rates as soon as they are released.</p> |
| MOOP                | <p>\$9,850</p> <p>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.</p>                                                                                 |

## 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                                | <p>\$1,850 per stay</p> <p>The plan covers 90 days each benefit period and up to 60 lifetime reserve days. Lifetime reserve days can only be used once.</p> |
| Outpatient hospital observation services | 20% coinsurance after your plan deductible is met                                                                                                           |
| Outpatient hospital                      | 20% coinsurance after your plan deductible is met                                                                                                           |
| Ambulatory surgical center               | 20% coinsurance after your plan deductible is met                                                                                                           |

### Primary care provider (PCP) and specialist services

| Benefit    | Your costs in our plan                                                                                                                                                                                                                                                     |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PCP        | \$0 copay after your plan deductible is met                                                                                                                                                                                                                                |
| Specialist | <p>0% - 20% coinsurance after your plan deductible is met</p> <p>0% coinsurance for certain physician specialist visits including: Cardiologists, Endocrinologists, Nephrologists, and Pulmonologists</p> <p>20% coinsurance for all other physician specialist visits</p> |

### Preventive, emergency, and urgent care

| Benefit         | Your costs in our plan |
|-----------------|------------------------|
| Preventive care | \$0 copay              |

| Benefit                                                                     | Your costs in our plan                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                             | 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.)                                 | \$115 copay for emergency care<br>\$40 copay for urgent care                                                                                                                                                                                                                        |
| Emergency and urgent care, including emergency ambulance (outside the U.S.) | \$115 copay for emergency care<br>\$115 copay for urgent care<br>20% coinsurance 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.

| Benefit                                                     | Your costs in our plan                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic tests and procedures                             | 20% coinsurance after your plan deductible is met<br><br>0% coinsurance for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing                                                                         |
| Lab services                                                | 20% coinsurance after your plan deductible is met<br><br>0% coinsurance for certain lab services including hemoglobin A1c, urine protein, prothrombin (protime), urine albumin, fecal immunochemical test (FIT), kidney health evaluation for members with diabetes (KED) and COVID-19 testing |
| Diagnostic radiology services, such as CT/ CAT scan and MRI | 20% coinsurance after your plan deductible is met                                                                                                                                                                                                                                              |
| Outpatient x-rays                                           | 20% coinsurance after your plan deductible is met                                                                                                                                                                                                                                              |

## Hearing services

| Benefit                 | Your costs in our plan                                                                                                                                                                                                                               |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic hearing exam | 20% coinsurance after your plan deductible is met                                                                                                                                                                                                    |
| 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) | <p>\$0 copay for covered services</p> <p>You get an annual benefit amount (allowance) of \$2,000 for covered services. You are responsible for any costs over this amount.</p> <p>Covered services include oral exams, x-rays, cleanings, fillings, extractions, and more.</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) | <p>0% - 20% coinsurance after your plan deductible is met</p> <p>0% coinsurance for diabetic eye exams</p> <p>20% coinsurance for all other Medicare-covered eye exams</p>                                                                                                                                                                               |
| Glaucoma screening                                | 20% coinsurance after your plan deductible is met                                                                                                                                                                                                                                                                                                        |
| 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 \$225 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>\$1,850 per stay</p> <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.</p>                             |
| Outpatient mental health therapy    | 20% coinsurance for individual sessions after your plan deductible is met 20% coinsurance for group sessions after your plan deductible is met |

| Benefit                        | Your costs in our plan                                                                                                                         |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient psychiatric therapy | 20% coinsurance for individual sessions after your plan deductible is met 20% 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 costs in our plan                                                                                   |
|-----------------------------|----------------------------------------------------------------------------------------------------------|
| SNF care                    | \$0 per day, days 1-20; \$221 per day, days 21-100<br>Our plan covers up to 100 days per benefit period. |
| Physical and speech therapy | 20% coinsurance after your plan deductible is met                                                        |
| Occupational therapy        | 20% 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 costs in our plan                            |
|--------------------------------------------|---------------------------------------------------|
| Ambulance<br>(ground or air, one-way trip) | 20% coinsurance after your plan deductible is met |
| 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 after your plan deductible is met |
| Part B Insulin     | \$35 copay                                        |
| Other Part B drugs | 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

Your costs may be lower if you qualify for "Extra Help."

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

|                        |                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Deductible phase       | You'll pay the plan's negotiated drug cost up to the deductible limit of \$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:

|                            | 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            | \$0                        | \$12                      | \$0                      | \$12                    | \$12                           |
| Tier 3: Preferred Brand    | 2%                         | 2%                        | 2%                       | 2%                      | 2%                             |
| Tier 4: Non-Preferred Drug | 25%                        | 25%                       | 25%                      | 25%                     | 25%                            |
| Tier 5: Specialty          | 25%                        | 25%                       | 25%                      | 25%                     | 25%                            |

### Long-term Supply

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

|                            | Preferred Retail<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            | \$0                                                      | \$36                       | \$0                       | \$36                     |
| Tier 3: Preferred Brand    | 2%                                                       | 2%                         | 2%                        | 2%                       |
| Tier 4: Non-Preferred Drug | 25%                                                      | 25%                        | 25%                       | 25%                      |
| Tier 5: Specialty          | A long-term supply is not available for drugs on Tier 5. |                            |                           |                          |

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Out-of-pocket threshold     | \$2,400 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>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. Qualifying members may be eligible for additional spending categories. See the Special Supplemental Benefits chart for more details.

| Benefit                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Over-the-Counter (OTC) Wallet | <p>You get a \$65 monthly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card.</p> <p>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 <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>20% coinsurance 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>20% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met</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 | 0% coinsurance for Medicare-covered diabetic supplies<br><br>We exclusively cover Accu-Chek/Roche and TRUE/Trividia blood glucose meters (BGMs) and test strips as preferred supplies.<br><br>0% coinsurance for Medicare-covered continuous glucose monitors (CGMs) |

## Fitness benefit

| Benefit                                  | Your costs in our plan                                                                                                                                                                                                                            |
|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Basic SilverSneakers® fitness membership | \$0 copay<br><br>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 podiatry visits after your plan deductible is met \$0 copay for non-Medicare covered podiatry visits<br><br>For non-Medicare covered services, we cover up to six visits every year. |

## Home care and support

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

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

## 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 after your plan deductible is met |
| Prosthetics, such as braces and artificial limbs                                     | 20% coinsurance after your plan deductible is met |

## 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 | 20% coinsurance for individual sessions after your plan deductible is met<br>20% coinsurance for group sessions after your plan deductible is met |

## 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 eligibility criteria, you may be eligible for additional benefits under our plan to help manage your overall health and wellness. Enrollment in the plan does not guarantee eligibility. You will receive special supplemental benefits after it is determined that you meet the eligibility requirements. However, you will not receive benefits for any time period before your eligibility was determined.                                                                                                                                                                                                                                                                                                                                                                                                          |
| Benefits                 | <p>After meeting all eligibility requirements, the \$65 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.</p> <p>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 <a href="https://www.cvs.com/Aetna">CVS.com/Aetna</a>, or shop by phone.</p> <p>Important: If you qualify, this wallet will be added to your current Aetna® Medicare Extra Benefits Card.</p> |

## 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                 | <p>If you qualify, you get:</p> <ul style="list-style-type: none"><li>• Extra Supports High Value Provider (HVP) Wallet:<ul style="list-style-type: none"><li>◦ \$30 monthly benefit amount (allowance) on an Extra Supports HVP Wallet loaded onto the Aetna® Medicare Extra Benefits Card</li></ul></li></ul>                                             |

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include certain cardiovascular disorders, chronic heart failure, and diabetes. 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.

## 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. |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## **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.

The Aetna C-SNP is available to Medicare members who have at least one of the qualifying chronic conditions. To ensure a successful enrollment process, we'll confirm with your healthcare provider that you have one of these eligible conditions. If verification of eligible condition is not received, involuntary disenrollment will occur.

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 **1-833-771-2456** (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 **1-833-595-1008** (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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To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (**1-800-633-4227**) (TTY users should call **1-877-486-2048**), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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# Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-833-771-2456 (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 **1-833-771-2456 (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).
- ☐ This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

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## Notice of Availability (NOA)

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እርስዎ ወጪ ሳያውጡ የቋንቋ አገልግሎቶችን ለመድረስ በዚህ ሰነድ ላይ ወዳለዉ ቁጥር ይደውሉ። (Amharic)

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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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ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

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