



# 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/H5521-762](https://www.aetna.com/H5521-762) 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.

# About this plan

**Aetna Medicare Elite Enhanced (PPO)** is a PPO plan. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care. 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:** Aetna Medicare Elite Enhanced (PPO) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your 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/H5521-762](https://www.aetna.com/medicare/H5521-762). 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 Elite Enhanced (PPO)**, 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:  
**Connecticut:** Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham

# 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 | \$99<br><br>You must continue to pay your Medicare Part B premium.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Plan deductible      | \$1,200 for certain in-network and out-of-network services.<br><br>Your deductible is what you'll pay before we begin to pay for services. The plan deductible applies to the following services provided by an in-network provider: inpatient hospital coverage, inpatient services in a psychiatric hospital, skilled nursing facility, therapeutic radiology, outpatient hospital services (including observation), ambulatory surgical center and dialysis. Additionally, the plan deductible applies to certain out-of-network services. |

## Out-of-pocket costs

|      |                                                                                                                                                                                                                                                                          |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MOOP | <p>\$7,150 for in-network services<br/>\$10,750 for in- and out-of-network services combined</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 in-network costs                                                                                      | Your out-of-network costs                         |
|------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Inpatient (unlimited number of days)     | \$458 per day, days 1-6; \$0 per day, days 7-90; \$0 for additional days after your plan deductible is met | 45% per stay after your plan deductible is met    |
| Outpatient hospital observation services | \$458 copay after your plan deductible is met                                                              | 45% coinsurance after your plan deductible is met |
| Outpatient hospital                      | \$450 copay after your plan deductible is met                                                              | 45% coinsurance after your plan deductible is met |
| Ambulatory surgical center               | \$400 copay after your plan deductible is met                                                              | 45% coinsurance after your plan deductible is met |

## Primary care provider (PCP) and specialist services

| Benefit    | Your in-network costs | Your out-of-network costs                         |
|------------|-----------------------|---------------------------------------------------|
| PCP        | \$0 copay             | 45% coinsurance after your plan deductible is met |
| Specialist | \$65 copay            | 45% coinsurance after your plan deductible is met |

## Preventive, emergency, and urgent care

| Benefit                                     | Your in-network costs                                                   | Your out-of-network costs                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Preventive care                             | \$0 copay                                                               | <p>0% - 45% coinsurance</p> <p>0% coinsurance for the pneumonia, flu/influenza, hepatitis B, and COVID-19 vaccines</p> <p>45% coinsurance for all other Medicare-covered preventive services</p> <p>For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.</p> |
| Emergency and urgent care (inside the U.S.) | <p>\$130 copay for emergency care</p> <p>\$50 copay for urgent care</p> | <p>\$130 copay for emergency care</p> <p>\$50 copay for urgent care</p>                                                                                                                                                                                                                                                   |

| Benefit                                                                     | Your in-network costs                                                                                                                                                                                                                                                           | Your out-of-network costs                                                                  |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Emergency and urgent care, including emergency ambulance (outside the U.S.) | \$130 copay for emergency care<br>\$130 copay for urgent care<br>\$300 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. | \$130 copay for emergency care<br>\$130 copay for urgent care<br>\$300 copay for ambulance |

## Diagnostic services, labs, and imaging

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

| Benefit                                                    | Your in-network costs                                                                                                                                                                                                                              | Your out-of-network costs                         |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Diagnostic tests and procedures                            | \$60 copay<br><br>\$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing                                                                         | 45% coinsurance after your plan deductible is met |
| Lab services                                               | \$15 copay<br><br>\$0 copay 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 | 45% coinsurance after your plan deductible is met |
| Diagnostic radiology services, such as CT/CAT scan and MRI | \$250 - \$300 copay<br><br>\$250 copay for services performed at a non-hospital facility<br>\$300 copay for services performed at a hospital facility                                                                                              | 45% coinsurance after your plan deductible is met |
| Outpatient x-rays                                          | \$20 copay                                                                                                                                                                                                                                         | 45% coinsurance after your plan deductible is met |

## Hearing services

| Benefit                 | Your in-network costs                                                                                                                                | Your out-of-network costs                         |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Diagnostic hearing exam | \$65 copay                                                                                                                                           | 45% coinsurance after your plan deductible is met |
| Routine hearing exam    | \$0 copay<br><br>You get one routine hearing exam every year. You can visit a provider in the NationsHearing® network or an out-of-network provider. | 45% coinsurance after your plan deductible is met |

| Benefit      | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Your out-of-network costs                                                                                                                                                                                                                                                                                                                                                           |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hearing aids | <p>When you use our authorized vendor, NationsHearing®, your copay amount will be required at the time of purchase based on the level of hearing aid selected. If you use an unauthorized vendor, you will have to pay upfront and request reimbursement from NationsHearing.</p> <ul style="list-style-type: none"> <li>• Level 1 (Standard): \$0 copay per ear, per year</li> <li>• Level 2 (Select): \$475 copay per ear, per year</li> <li>• Level 3 (Superior Plus): \$650 copay per ear, per year</li> <li>• Level 4 (Advanced): \$895 copay per ear, per year</li> <li>• Level 5 (Advanced Plus): \$1,300 copay per ear, per year</li> <li>• Level 6 (Specialty): \$1,700 copay per ear, per year</li> </ul> | <p>If you do not use our authorized vendor, NationsHearing, for this benefit, you will have to pay out of pocket at the time of purchase and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount.</p> |

## Dental services

| Benefit                                | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Your out-of-network costs                                                                           |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Dental services (non-Medicare covered) | <p>\$0 copay for preventive services<br/>20% - 50% coinsurance for comprehensive services</p> <p>You get an annual benefit amount (allowance) of \$1,500 for covered comprehensive services. You are responsible for the cost of any comprehensive services over this amount.</p> <p>Covered comprehensive services include fillings, extractions, crowns, and more.</p> <p>Covered preventive services include oral exams, cleanings, and x-rays. There is no copay for these services when using an in-network provider. Covered preventive services do not count toward your annual benefit amount.</p> <p>You can use a provider in or out of the Aetna Dental PPO Network, which is different from your medical network, for covered services. However, if you use a provider outside of the network, you may be required to pay in full for services and submit a request for reimbursement.</p> <p>See EOC for details on exclusions and limitations.</p> | <p>50% coinsurance for preventive services<br/>50% - 70% coinsurance for comprehensive services</p> |

## Vision services

| Benefit                                           | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Your out-of-network costs                                                                                                                                                                                    |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 - \$65 copay<br>\$0 copay for diabetic eye exams<br>\$65 copay for all other Medicare-covered eye exams                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 45% coinsurance after your plan deductible is met                                                                                                                                                            |
| Glaucoma screening                                | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 45% coinsurance after your plan deductible is met                                                                                                                                                            |
| Routine eye exam (one exam every year)            | \$0 copay with an EyeMed network provider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | The out-of-network routine eye exam is covered up to \$50.<br><br>You may be required to pay up front and submit a reimbursement request to EyeMed. You will be responsible for any billed amount over \$50. |
| Contacts and eyeglasses                           | You get an annual benefit amount (allowance) of \$150 for covered prescription eyewear.<br><br>We have teamed up with EyeMed to provide this benefit. When you use an EyeMed network provider, your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll need to pay the difference. If you use a provider outside of the EyeMed network, you may be required to pay up front and request reimbursement up to your benefit amount. You may also be responsible for additional costs. See EOC for details. |                                                                                                                                                                                                              |

## Mental health services

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

| Benefit                             | Your in-network costs                                                                                                                                                        | Your out-of-network costs                                                                                                                         |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient psychiatric hospital stay | \$392 per day, days 1-6; \$0 per day, days 7-90 after your plan deductible is met<br><br>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. | 45% per stay after your plan deductible is met                                                                                                    |
| Outpatient mental health therapy    | \$65 copay for individual sessions<br>\$65 copay for group sessions                                                                                                          | 45% coinsurance for individual sessions after your plan deductible is met<br>45% coinsurance for group sessions after your plan deductible is met |
| Outpatient psychiatric therapy      | \$65 copay for individual sessions<br>\$65 copay for group sessions                                                                                                          | 45% coinsurance for individual sessions after your plan deductible is met<br>45% coinsurance for group sessions after your plan deductible is met |

## Skilled nursing facility (SNF) and therapy

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification. Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

| Benefit                     | Your in-network costs                                                                                                                           | Your out-of-network costs                         |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| SNF care                    | \$10 per day, days 1-20; \$221 per day, days 21-100 after your plan deductible is met<br><br>Our plan covers up to 100 days per benefit period. | 45% per stay after your plan deductible is met    |
| Physical and speech therapy | \$20 copay                                                                                                                                      | 45% coinsurance after your plan deductible is met |
| Occupational therapy        | \$20 copay                                                                                                                                      | 45% coinsurance after your plan deductible is met |

## Ambulance and routine transportation

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

| Benefit                                 | Your in-network costs                                                                   | Your out-of-network costs                                                                                                                                   |
|-----------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ambulance (ground or air, one-way trip) | \$300 copay for ground ambulance services<br>20% coinsurance for air ambulance services | \$300 copay for ground ambulance services after your plan deductible is met<br>20% coinsurance for air ambulance services after your plan deductible is met |
| Routine, non-emergency transportation   | Not Covered                                                                             | Not Covered                                                                                                                                                 |

## Medicare Part B drugs

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

| Benefit            | Your in-network costs | Your out-of-network costs                         |
|--------------------|-----------------------|---------------------------------------------------|
| Chemotherapy drugs | 20% coinsurance       | 45% coinsurance after your plan deductible is met |
| Part B Insulin     | \$35 copay            | \$35 copay after your plan deductible is met      |
| Other Part B drugs | 20% coinsurance       | 45% 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 (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 \$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:

|                            | <b>Preferred Retail</b> | <b>Standard Retail</b> | <b>Preferred Mail</b> | <b>Standard Mail</b> | <b>Long-Term Care (LTC)</b> |
|----------------------------|-------------------------|------------------------|-----------------------|----------------------|-----------------------------|
|                            | <b>30-day</b>           | <b>30-day</b>          | <b>30-day</b>         | <b>30-day</b>        | <b>31-day</b>               |
| Tier 1: Preferred Generic  | \$0                     | \$5                    | \$0                   | \$5                  | \$5                         |
| Tier 2: Generic            | \$5                     | \$12                   | \$5                   | \$12                 | \$12                        |
| Tier 3: Preferred Brand    | 17%                     | 17%                    | 17%                   | 17%                  | 17%                         |
| Tier 4: Non-Preferred Drug | 28%                     | 28%                    | 28%                   | 28%                  | 28%                         |
| 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:

|                            | <b>Preferred Retail</b>                                  | <b>Standard Retail</b> | <b>Preferred Mail</b> | <b>Standard Mail</b> |
|----------------------------|----------------------------------------------------------|------------------------|-----------------------|----------------------|
|                            | <b>100-day</b>                                           | <b>100-day</b>         | <b>100-day</b>        | <b>100-day</b>       |
| Tier 1: Preferred Generic  | \$0                                                      | \$15                   | \$0                   | \$15                 |
| Tier 2: Generic            | \$15                                                     | \$36                   | \$5                   | \$36                 |
| Tier 3: Preferred Brand    | 17%                                                      | 17%                    | 17%                   | 17%                  |
| Tier 4: Non-Preferred Drug | 28%                                                      | 28%                    | 28%                   | 28%                  |
| 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 | <p>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.</p> <p>Part D preventive vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible.</p> <p>Check your formulary guide for a list of covered Part D insulins and vaccines.</p> |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Other covered benefits

### Alternative medicine

| Benefit               | Your in-network costs                                                                                                                                                                                | Your out-of-network costs                                                                         |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Acupuncture           | <p>\$65 copay for Medicare-covered acupuncture visits</p> <p>Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.</p> | <p>45% coinsurance for Medicare-covered acupuncture visits after your plan deductible is met</p>  |
| Chiropractic services | <p>\$15 copay for Medicare-covered chiropractic visits</p> <p>Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.</p>                  | <p>45% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met</p> |

## Diabetic supplies

| Benefit           | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Your out-of-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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) after your plan deductible is met</p> | <p>0% - 20% coinsurance for Medicare-covered diabetic supplies after your plan deductible is met</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>45% coinsurance for Medicare-covered continuous glucose monitors (CGMs) after your plan deductible is met</p> |

## Fitness benefit

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

## Foot care (podiatry services)

| Benefit                  | Your in-network costs                                                                                          | Your out-of-network costs                                                              |
|--------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| Foot exams and treatment | \$65 copay for Medicare-covered podiatry visits<br><br>Non-Medicare covered podiatry services are not covered. | 45% coinsurance for Medicare-covered podiatry visits after your plan deductible is met |

## Home care and support

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

| Benefit                                                                                            | Your in-network costs                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Your out-of-network costs                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Home health care, such as part-time skilled nursing and health aide services, and physical therapy | \$0 copay for Medicare-covered home health care services<br><br>Non-Medicare covered home health care services are not covered.                                                                                                                                                                                                                                                                                                                                                              | 45% coinsurance for Medicare-covered home health care services after your plan deductible is met                                                                                                                                                                                                                                                                          |
| Meal benefit (post-discharge)                                                                      | \$0 copay for the meal benefit when you use our authorized vendor, NationsMarket™<br><br>After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 14 freshly prepared meals for a 7-day period. These meals are provided to help support your recovery or manage your health conditions. We have teamed up with our authorized vendor NationsMarket™ to provide this benefit. | If you do not use our authorized vendor NationsMarket for this benefit, you will have to pay out of pocket at the time of purchase and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount. |

## Medical equipment and supplies

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

| Benefit                                                                              | Your in-network costs | Your out-of-network costs                         |
|--------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------|
| Durable medical equipment (DME), such as wheelchairs, crutches, and oxygen equipment | 20% coinsurance       | 45% coinsurance after your plan deductible is met |
| Prosthetics, such as braces and artificial limbs                                     | 20% coinsurance       | 45% 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 in-network costs                                               | Your out-of-network costs                                                                                                                         |
|--------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient substance use disorder services | \$65 copay for individual sessions<br>\$65 copay for group sessions | 45% coinsurance for individual sessions after your plan deductible is met<br>45% coinsurance for group sessions after your plan deductible is met |

## Visitor/traveler benefit

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

| Benefit                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Visitor/traveler program:<br>Explorer | This benefit allows you to remain in your plan for up to 12 months when you are outside your plan's service area. While traveling within the United States, you can see an Aetna Medicare participating provider and pay in-network cost shares. If you use an out-of-network provider while participating in the visitor/traveler program, your cost share may be higher. Not all providers participate in the multi-state network. You must select a PCP in the visitor/travel area in order for services to be covered. Contact us for help finding a participating provider in the area you're traveling to. |

## 24-Hour Nurse Line

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

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

## Special supplemental benefits

Our plan offers additional benefits to qualifying members. See the EOC for a full list of eligibility criteria.

## **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/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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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.
- ☐ In addition to your monthly plan premium, 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.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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## Notice of Availability (NOA)

### TTY: 711

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