

C-SNP
2027



Aetna[®] Medicare benefits and enrollment guide

SOUTHWEST C-SNP PLANS

PLANS:

Aetna Medicare Chronic Care (HMO C-SNP) - H1609-098

Aetna Medicare Chronic Care (HMO C-SNP) - H1609-099

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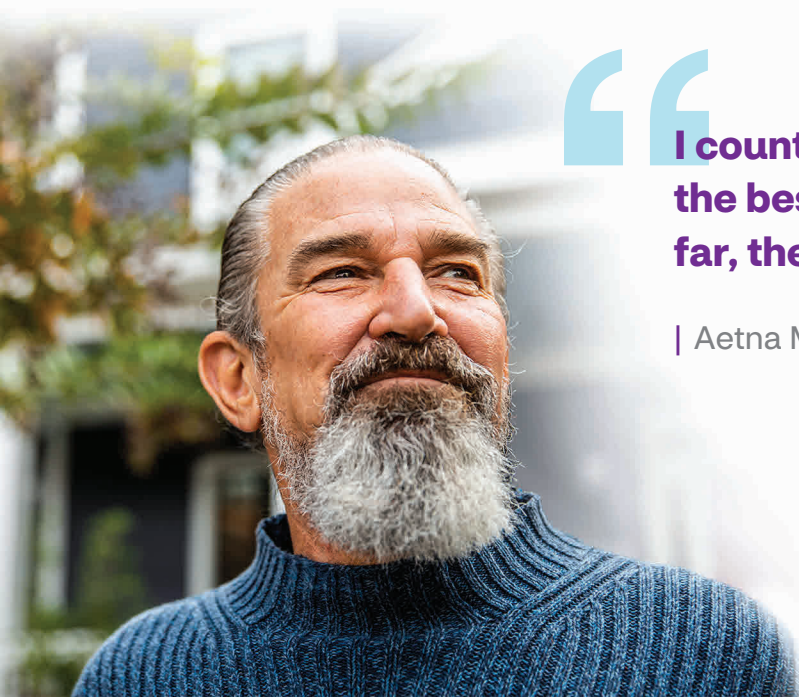
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I count on my health insurance to offer the best plan for my needs. Aetna is, by far, the best health insurance for me.* ”

| Aetna Medicare member

*Member feedback has been edited for length and clarity; member not pictured.

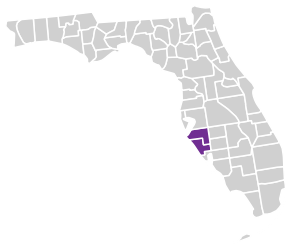




See what's available in your area

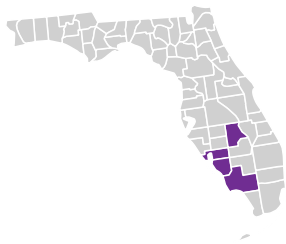
We're here to walk you through your options. And help you feel good about enrolling in a new plan or switching coverage.

Aetna Medicare Chronic Care (HMO C-SNP) (H1609-098)



Florida: Manatee, Sarasota

Aetna Medicare Chronic Care (HMO C-SNP) (H1609-099)



Florida: Charlotte, Collier, Highlands, Lee

MP27-FLC05.1



For more information, see the **Summary of Benefits**.

Or call us at **1-833-771-2456 (TTY: 711)**.

Hours of operation: April 1–September 30: 8 AM–8 PM, Monday–Friday.

October 1–March 31: 8 AM–8 PM, 7 days a week.



We've got your back every step of the way

So you can manage your
Aetna® Medicare plan with confidence



Providers you trust

Our coverage helps connect you with the providers and hospitals you count on for care.



Added features

Our plans offer all of the benefits of Original Medicare, plus other benefits, programs and services.



And much more to help you feel your best

Read on to get the whole story.

Get started

What to consider before
choosing your plan



We're here to help you choose Find the right plan for you

Get started

- ✓ Make a list of your preferred providers.
- ✓ Have your current prescriptions handy.
- ✓ Note your current and upcoming needs, like appointments, procedures, testing and medical equipment.
- ✓ Consider any other benefits you use.

A Chronic Condition Special Needs Plan (C-SNP) is designed to support those who are Medicare eligible, live in the plan's service area and have one or more severe or disabling chronic conditions. Plan eligibility is based on having a qualifying chronic condition, including certain cardiovascular disorders, chronic heart failure and diabetes.

Check out the plan's network.

- See if your providers are in the network. In general, you'll pay less when you visit these providers.
- Confirm if you can go out of network or if the plan has a travel benefit.
- Check to see if your plan requires referrals for specialists.

Out-of-pocket costs. Review the premium, deductibles, copays and coinsurance for the services and medicine you use.

Maximum out-of-pocket limit. This is the most you'll pay out of pocket for covered services during the current plan year.

Look at your prescriptions.

- **Find medication in the plan's formulary (drug list).** This includes common generic and brand-name drugs your plan covers.
- **Learn what tier your drugs are on.** The list has levels called "tiers." Drugs in each tier may have different costs.
- **See if you'll have a deductible.** Generally, it only applies to drugs on Tiers 3, 4 and 5.
- **Look for coverage rules.** Examples include step therapy or prior authorization (pre-approval) that you'll have to meet before the health plan covers your medication.
- **See if your pharmacy is in network.** Or find a preferred pharmacy to help lower your costs.

See the costs for benefits you use regularly. Some examples include:

- Primary care visits
- Specialist visits
- Routine testing/imaging
- Dental, vision and hearing coverage
- Diabetic supplies
- Medical equipment

Get the coverage you need. The right plan will take care of your health needs and your budget. Keep in mind:

- Some plans have higher copays but with lower premiums, which may be a good option.
- If you need more care, a plan with a higher premium, lower cost-sharing and lower maximum out-of-pocket costs may be right for you.



Understand how drug coverage works

Deductible phase

During this phase, you'll usually pay the negotiated cost of your drugs until you meet your plan's deductible, if your plan has one.

Initial coverage phase

During this phase, you'll pay a copayment or coinsurance (your share of the cost) for each prescription you fill.

Catastrophic coverage phase

During this phase, you'll pay \$0 out of pocket for covered Part D prescriptions. You'll stay in this phase through the end of the plan year.

Find the resources you need



Plan benefits

View plan benefits in the **Summary of Benefits** or at **AetnaMedicare.com**



Glossary

See our glossary of Medicare and insurance terms at **aet.na/Glossary**



Providers

Look for providers at **AetnaMedicare.com/findprovider**



In-network pharmacy

Find an in-network pharmacy at **AetnaMedicare.com/findpharmacy**



Prescription drugs

Search for your prescription drugs at **AetnaMedicare.com/formulary**



We're here to help you

To speak with a licensed sales agent in your area, call us at **1-833-771-2456 (TTY: 711)**.



Hours of operation

April 1–September 30: 8 AM–8 PM, Monday–Friday.

October 1–March 31: 8 AM–8 PM, 7 days a week.





GOOD TO KNOW

5 reasons to have a primary care provider (PCP)

They'll get to know you and can:

1. **Coordinate** your care with specialists
2. **Provide** access to wellness tests and screenings
3. **Help** you monitor and take care of any long-term health issues, like diabetes or high blood pressure
4. **Review** and take care of your over-the-counter and prescription medications
5. **Find** health problems early, when they may be more treatable

Medicare 101

Understand how
your plan works

You're eligible for Medicare if you:

☒ Are age 65 or older

☒ Are under 65 and have certain disabilities

☒ Have a disability, end-stage renal disease (ESRD) or ALS (also called Lou Gehrig's disease)



Compare the differences



Original Medicare



Medicare Advantage (Part C) plan



Available providers and hospitals

You can go to any provider or hospital that accepts Medicare.

You may have to use a network of providers and hospitals.



Prescription drug coverage

You have to buy a separate Part D plan if you want or need prescription drug coverage.

You may not have to buy a separate Part D plan because it may include prescription drug coverage.



Total out-of-pocket costs

You may not have a limit on how much you pay out of pocket each year.

You can help lower your expenses — it caps your annual out-of-pocket costs for covered medical services.

Keep in mind

- You don't have to sign up for Original Medicare if you already get Social Security benefits or railroad retirement checks when you first become eligible for Medicare.
- You can sign up even if you don't plan to retire at 65. Contact Social Security about three months before you turn 65 to sign up for Medicare.
- You can ask your employer for guidance. If you have medical coverage through your employer, ask them if you should sign up for Part B when you're first eligible for Medicare.

Get to know the parts of Medicare

Parts A and B make up Original Medicare, which the federal government provides.



Part A

Hospital insurance:

- Covers inpatient hospital and rehabilitation facility care, including X-rays, surgeries and radiation treatment
- Also covers skilled nursing facility, hospice and home health care

Most people won't pay a premium for Part A.



Part B

Medical insurance:

- Covers outpatient hospital and home health care
- Also covers ambulance, provider and preventive services

You may pay a monthly premium for Part B. The premium is usually taken out of your Social Security check.

Parts C and D are offered by private insurers, not the federal government.



Part C

Medicare Advantage plan — an alternative to Original Medicare:

- Covers all of your Part A and B benefits
- May cover your prescription drugs, too (also known as Part D)
- Can include other benefits, like eyewear, hearing aids, wellness services and online tools and resources
- May require you to see in-network providers or specialists

You may pay a monthly premium for Part C. You must keep paying your Part B premium, too.



Part D

Medicare prescription drug plan:

- Covers your prescription drugs
- Is often included in a Medicare Advantage plan
- Can buy separately to go with Original Medicare

You may pay a monthly premium for Part D unless you qualify for Part D Extra Help.

When can I enroll in a Medicare Part C or Part D plan?

To ensure you'll always have coverage, it's important to know your enrollment period.

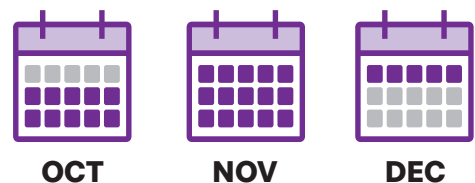


Initial Enrollment Period

Your IEP is the 7-month period that begins three months before your 65th birthday, includes your birthday month and ends three months afterward. There is an exception: if your birthday falls on the first of any month, your 7-month IEP begins and ends one month sooner.

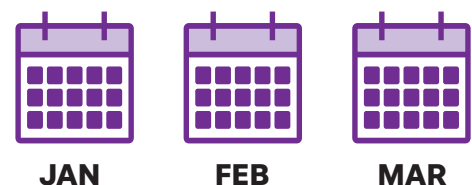
Annual Enrollment Period

You can enroll in or change your Medicare plan from **October 15** through **December 7** each year.



Open Enrollment Period

If you're enrolled in a Medicare Advantage (Part C) plan, you may be able to change your plan from **January 1 to March 31. This is called the Open Enrollment Period.** You can change your plan only once during this time period.



Special Enrollment Period*

You may be able to enroll in or change Medicare plans if you:

- Lose employer coverage
- Qualify for or lose full Medicaid eligibility
- Move to a new service area
- Live in, or move in or out of an institution

If you have full Medicaid coverage, you may use a monthly Special Enrollment Period to switch to another Fully Integrated Dual Eligible Special Needs Plan or Highly Integrated Dual Special Needs Plan.

*Some life changes can qualify you for the Special Enrollment Period. Call us or check your enrollment form for more information.



 This is my plan.

Aetna Medicare Chronic Care (HMO C-SNP)
H1609-098

Summary of Benefits 2027

January 1, 2027 through December 31, 2027

This is a summary of your plan's costs and coverage. For a complete list of what we cover and any limitations, review the plan's *Evidence of Coverage* (EOC) at [AetnaMedicare.com/H1609-098](https://www.aetna.com/medicare/H1609-098) 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-H1609.098.1

About this plan

Aetna Medicare Chronic Care (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:** Usually, your PCP must give approval before you use other network providers. You don't need a referral for emergency or urgently needed care.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit [AetnaMedicare.com/H1609-098](https://www.aetna.com/H1609-098). 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 (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 counties:
Florida: Manatee, Sarasota

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.
Plan deductible	\$0

Out-of-pocket costs	
MOOP	\$3,600 Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.

Medical and hospital benefits

Hospital coverage

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

Benefit	Your costs in our plan
Inpatient (unlimited number of days)	\$250 per day, days 1-7; \$0 per day, days 8-90; \$0 for additional days
Outpatient hospital observation services	\$250 copay
Outpatient hospital	\$250 copay
Ambulatory surgical center	\$200 copay

Primary care provider (PCP) and specialist services

Benefit	Your costs in our plan
PCP	\$0 copay
Specialist	\$0 - \$20 copay \$0 copay for certain physician specialist visits including: Cardiologists, Endocrinologists, Nephrologists, and Pulmonologists \$20 copay for all other physician specialist visits

Preventive, emergency, and urgent care

Benefit	Your costs in our plan
Preventive care	\$0 copay For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.
Emergency and urgent care (inside the U.S.)	\$150 copay for emergency care \$40 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	\$150 copay for emergency care \$150 copay for urgent care \$250 copay for ambulance

Benefit	Your costs in our plan
	Maximum coverage: \$250,000. This is the most we will pay for the combined cost of emergency care, urgent care, and emergency ambulance services received outside of the U.S.

Diagnostic services, labs, and imaging

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification. You may have to get a referral from your PCP before you can receive these services.

Benefit	Your costs in our plan
Diagnostic tests and procedures	\$0 - \$200 copay \$0 copay for services performed at a non-hospital facility \$200 copay for services performed at a hospital facility \$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing
Lab services	\$0 copay
Diagnostic radiology services, such as CT/ CAT scan and MRI	\$0 - \$250 copay \$0 copay for services performed at a non-hospital facility \$250 copay for services performed at a hospital facility
Outpatient x-rays	\$0 - \$100 copay \$0 copay for services performed at a non-hospital facility \$100 copay for services performed at a hospital facility

Hearing services

Benefit	Your costs in our plan
Diagnostic hearing exam	\$20 copay
Routine hearing exam	\$0 copay You get one routine hearing exam every year with a provider in the NationsHearing® network.
Hearing aids	You get an annual benefit amount (allowance) of \$1,000 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through an authorized NationsHearing® network provider.

Dental services

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

Benefit	Your costs in our plan
Dental services (non-Medicare covered)	\$0 copay for covered services You get an annual benefit amount (allowance) of \$1,000 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, cleanings, fillings, extractions, crowns, dentures, and more. We have teamed up with Liberty Dental to provide your dental coverage. This benefit uses the Liberty Dental network, which is different from your medical network, for covered services. If you choose a provider outside of the Liberty Dental network, services will not be covered. See EOC for details on exclusions and limitations.

Vision services

Benefit	Your costs in our plan
Diagnostic eye exam (includes diabetic eye exams)	\$0 copay
Glaucoma screening	\$0 copay
Routine eye exam (one exam every year)	\$0 copay with an iCare network optometrist
Contacts and eyeglasses	With this plan, each calendar year you can get one of the following through an iCare network optometrist: • Eyeglasses: Up to two pairs every year from the iCare "covered in full" eyewear collection at no cost OR • An annual benefit amount (allowance) of \$200 for prescription eyewear including contact lenses or eyeglasses (including lenses and frames), and • Upgrades: including UV protection and scratch coating We have teamed up with iCare Health Solutions to provide this benefit.

Mental health services

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

Benefit	Your costs in our plan
Inpatient psychiatric hospital stay	\$250 per day, days 1-7; \$0 per day, days 8-90

Benefit	Your costs in our plan
	There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.
Outpatient mental health therapy	\$10 copay for individual sessions \$10 copay for group sessions
Outpatient psychiatric therapy	\$10 copay for individual sessions \$10 copay for group sessions

Skilled nursing facility (SNF) and therapy

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

Benefit	Your costs in our plan
SNF care	\$0 per day, days 1-20; \$221 per day, days 21-100 Our plan covers up to 100 days per benefit period.
Physical and speech therapy	\$20 copay
Occupational therapy	\$20 copay

Ambulance and routine transportation

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

Benefit	Your costs in our plan
Ambulance (ground or air, one-way trip)	\$250 copay for ground ambulance services 20% coinsurance for air ambulance services
Routine, non-emergency transportation	Not Covered

Medicare Part B drugs

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

Benefit	Your costs in our plan
Chemotherapy drugs	20% coinsurance
Part B Insulin	\$35 copay
Other Part B drugs	20% coinsurance

Medicare Part D drugs

Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes. Some drugs require prior authorization. This means you must get approval from us first before we'll cover them.

Prescription drug costs

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

Formulary name: B2_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 \$300. The deductible applies to drugs on Tiers 3, 4, and 5.
Initial coverage phase	The plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription filled. You will pay the lesser of the listed copay/coinsurance below or the negotiated cost of the drug. These cost shares may also apply to home infusion drugs when obtained through your Part D benefit. Costs may differ based on pharmacy type or status.

One-month Supply

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

	Preferred Retail 30-day	Standard Retail 30-day	Preferred Mail 30-day	Standard Mail 30-day	Long-Term Care (LTC) 31-day
Tier 1: Preferred Generic	\$0	\$5	\$0	\$5	\$5
Tier 2: Generic	\$0	\$12	\$0	\$12	\$12
Tier 3: Preferred Brand	22%	22%	22%	22%	22%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%
Tier 5: Specialty	30%	30%	30%	30%	30%

Long-term Supply

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

	Preferred Retail 100-day	Standard Retail 100-day	Preferred Mail 100-day	Standard Mail 100-day
Tier 1: Preferred Generic	\$0	\$15	\$0	\$15
Tier 2: Generic	\$0	\$36	\$0	\$36
Tier 3: Preferred Brand	22%	22%	22%	22%
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. You'll pay \$0 for generic and brand name drugs in this phase.

Insulins and vaccines	Part D insulins: You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or Part D phase you are in, even if you haven't paid your deductible. Part D preventive vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible. Check your formulary guide for a list of covered Part D insulins and vaccines.
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Other covered benefits

Aetna® Medicare Extra Benefits Card

You get an Aetna Medicare Extra Benefits Card to help pay for certain everyday expenses. Qualifying members may be eligible for additional spending categories. See the Special Supplemental Benefits chart for more details.

Benefit	
Over-the-Counter (OTC) Wallet	You get a \$95 monthly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card. You can use your Over-the-Counter (OTC) Wallet to help pay for certain OTC health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. Approved products can be purchased in-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at CVS.com/Aetna, or shop by phone. Important: • If you received an Aetna Medicare Extra Benefits Card in 2026 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2027 plan year. • If you are a new member or were not enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026, you should get a new card before your plan begins. • If you enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026 and changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.

Alternative medicine

Benefit	Your costs in our plan
Acupuncture	\$20 copay for Medicare-covered acupuncture visits

Benefit	Your costs in our plan
	Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.
Chiropractic services	\$20 copay for Medicare-covered chiropractic visits Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.

Diabetic supplies

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

Fitness benefit

Benefit	Your costs in our plan
Basic SilverSneakers® fitness membership	\$0 copay 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 \$0 copay for non-Medicare covered podiatry visits For non-Medicare covered services, we cover up to twelve 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

Benefit	Your costs in our plan
	Non-Medicare covered home health care services are not covered.
Meal benefit (post-discharge)	\$0 copay for the meal benefit when you use our authorized vendor, NationsMarket™ After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 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.

Medical equipment and supplies

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

Benefit	Your costs in our plan
Durable medical equipment (DME), such as wheelchairs, crutches, and oxygen equipment	20% coinsurance
Prosthetics, such as braces and artificial limbs	20% coinsurance

Resources For Living®

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

Substance use disorder services

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

Benefit	Your costs in our plan
Outpatient substance use disorder services	\$10 copay for individual sessions \$10 copay for group sessions

24-Hour Nurse Line

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

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

Special supplemental benefits

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

Extra Supports Wallet	
Eligibility requirements	If you are diagnosed with one or more of the chronic conditions listed in the EOC and meet all 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	After meeting all eligibility requirements, the \$95 monthly benefit amount in the Over-the-Counter (OTC) Wallet will change to the Extra Supports Wallet with additional spending categories. Qualified members can use this wallet to help pay for certain healthy foods, over-the-counter (OTC) health and wellness products, transportation, utilities, and personal care products. This will replace your OTC Wallet. You will not get any additional funds applied to your card. Approved products can be purchased in-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at CVS.com/ Aetna, or shop by phone. Important: If you qualify, this wallet will be added to your current Aetna® Medicare Extra Benefits Card.

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include 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.

Recovery at Home Program

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



 This is my plan.

Aetna Medicare Chronic Care (HMO C-SNP)
H1609-099

Summary of Benefits 2027

January 1, 2027 through December 31, 2027

This is a summary of your plan's costs and coverage. For a complete list of what we cover and any limitations, review the plan's *Evidence of Coverage* (EOC) at [AetnaMedicare.com/H1609-099](https://www.aetna.com/H1609-099) 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-H1609.099.1

About this plan

Aetna Medicare Chronic Care (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:** Usually, your PCP must give approval before you use other network providers. You don't need a referral for emergency or urgently needed care.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit [AetnaMedicare.com/H1609-099](https://www.aetna.com/H1609-099). 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 (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 counties:
Florida: Charlotte, Collier, Highlands, Lee

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.
Plan deductible	\$0

Out-of-pocket costs	
MOOP	\$3,900 Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.

Medical and hospital benefits

Hospital coverage

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

Benefit	Your costs in our plan
Inpatient (unlimited number of days)	\$250 per day, days 1-7; \$0 per day, days 8-90; \$0 for additional days
Outpatient hospital observation services	\$250 copay
Outpatient hospital	\$250 copay
Ambulatory surgical center	\$200 copay

Primary care provider (PCP) and specialist services

Benefit	Your costs in our plan
PCP	\$0 copay
Specialist	\$0 - \$25 copay \$0 copay for certain physician specialist visits including: Cardiologists, Endocrinologists, Nephrologists, and Pulmonologists \$25 copay for all other physician specialist visits

Preventive, emergency, and urgent care

Benefit	Your costs in our plan
Preventive care	\$0 copay For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.
Emergency and urgent care (inside the U.S.)	\$150 copay for emergency care \$40 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	\$150 copay for emergency care \$150 copay for urgent care \$250 copay for ambulance

Benefit	Your costs in our plan
	Maximum coverage: \$250,000. This is the most we will pay for the combined cost of emergency care, urgent care, and emergency ambulance services received outside of the U.S.

Diagnostic services, labs, and imaging

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification. You may have to get a referral from your PCP before you can receive these services.

Benefit	Your costs in our plan
Diagnostic tests and procedures	\$0 - \$200 copay \$0 copay for services performed at a non-hospital facility \$200 copay for services performed at a hospital facility \$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing
Lab services	\$0 copay
Diagnostic radiology services, such as CT/ CAT scan and MRI	\$0 - \$250 copay \$0 copay for services performed at a non-hospital facility \$250 copay for services performed at a hospital facility
Outpatient x-rays	\$0 - \$100 copay \$0 copay for services performed at a non-hospital facility \$100 copay for services performed at a hospital facility

Hearing services

Benefit	Your costs in our plan
Diagnostic hearing exam	\$25 copay
Routine hearing exam	\$0 copay You get one routine hearing exam every year with a provider in the NationsHearing® network.
Hearing aids	You get an annual benefit amount (allowance) of \$1,000 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through an authorized NationsHearing® network provider.

Dental services

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

Benefit	Your costs in our plan
Dental services (non-Medicare covered)	\$0 copay for covered services You get an annual benefit amount (allowance) of \$1,000 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, cleanings, fillings, extractions, crowns, dentures, and more. We have teamed up with Liberty Dental to provide your dental coverage. This benefit uses the Liberty Dental network, which is different from your medical network, for covered services. If you choose a provider outside of the Liberty Dental network, services will not be covered. See EOC for details on exclusions and limitations.

Vision services

Benefit	Your costs in our plan
Diagnostic eye exam (includes diabetic eye exams)	\$0 copay
Glaucoma screening	\$0 copay
Routine eye exam (one exam every year)	\$0 copay with an iCare network optometrist
Contacts and eyeglasses	With this plan, each calendar year you can get one of the following through an iCare network optometrist: • Eyeglasses: Up to two pairs every year from the iCare "covered in full" eyewear collection at no cost OR • An annual benefit amount (allowance) of \$200 for prescription eyewear including contact lenses or eyeglasses (including lenses and frames), and • Upgrades: including UV protection and scratch coating We have teamed up with iCare Health Solutions to provide this benefit.

Mental health services

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

Benefit	Your costs in our plan
Inpatient psychiatric hospital stay	\$250 per day, days 1-7; \$0 per day, days 8-90

Benefit	Your costs in our plan
	There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.
Outpatient mental health therapy	\$10 copay for individual sessions \$10 copay for group sessions
Outpatient psychiatric therapy	\$10 copay for individual sessions \$10 copay for group sessions

Skilled nursing facility (SNF) and therapy

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

Benefit	Your costs in our plan
SNF care	\$0 per day, days 1-20; \$221 per day, days 21-100 Our plan covers up to 100 days per benefit period.
Physical and speech therapy	\$20 copay
Occupational therapy	\$20 copay

Ambulance and routine transportation

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

Benefit	Your costs in our plan
Ambulance (ground or air, one-way trip)	\$250 copay for ground ambulance services 20% coinsurance for air ambulance services
Routine, non-emergency transportation	Not Covered

Medicare Part B drugs

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

Benefit	Your costs in our plan
Chemotherapy drugs	20% coinsurance
Part B Insulin	\$35 copay
Other Part B drugs	20% coinsurance

Medicare Part D drugs

Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes. Some drugs require prior authorization. This means you must get approval from us first before we'll cover them.

Prescription drug costs

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

Formulary name: B2_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 \$300. The deductible applies to drugs on Tiers 3, 4, and 5.
Initial coverage phase	The plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription filled. You will pay the lesser of the listed copay/coinsurance below or the negotiated cost of the drug. These cost shares may also apply to home infusion drugs when obtained through your Part D benefit. Costs may differ based on pharmacy type or status.

One-month Supply

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

	Preferred Retail 30-day	Standard Retail 30-day	Preferred Mail 30-day	Standard Mail 30-day	Long-Term Care (LTC) 31-day
Tier 1: Preferred Generic	\$0	\$5	\$0	\$5	\$5
Tier 2: Generic	\$0	\$12	\$0	\$12	\$12
Tier 3: Preferred Brand	22%	22%	22%	22%	22%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%
Tier 5: Specialty	30%	30%	30%	30%	30%

Long-term Supply

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

	Preferred Retail 100-day	Standard Retail 100-day	Preferred Mail 100-day	Standard Mail 100-day
Tier 1: Preferred Generic	\$0	\$15	\$0	\$15
Tier 2: Generic	\$0	\$36	\$0	\$36
Tier 3: Preferred Brand	22%	22%	22%	22%
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. You'll pay \$0 for generic and brand name drugs in this phase.

Insulins and vaccines	Part D insulins: You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or Part D phase you are in, even if you haven't paid your deductible. Part D preventive vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible. Check your formulary guide for a list of covered Part D insulins and vaccines.
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Other covered benefits

Aetna® Medicare Extra Benefits Card

You get an Aetna Medicare Extra Benefits Card to help pay for certain everyday expenses. Qualifying members may be eligible for additional spending categories. See the Special Supplemental Benefits chart for more details.

Benefit	
Over-the-Counter (OTC) Wallet	You get a \$140 monthly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card. You can use your Over-the-Counter (OTC) Wallet to help pay for certain OTC health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. Approved products can be purchased in-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at CVS.com/Aetna, or shop by phone. Important: • If you received an Aetna Medicare Extra Benefits Card in 2026 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2027 plan year. • If you are a new member or were not enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026, you should get a new card before your plan begins. • If you enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026 and changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.

Alternative medicine

Benefit	Your costs in our plan
Acupuncture	\$25 copay for Medicare-covered acupuncture visits

Benefit	Your costs in our plan
	Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.
Chiropractic services	\$20 copay for Medicare-covered chiropractic visits Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.

Diabetic supplies

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

Fitness benefit

Benefit	Your costs in our plan
Basic SilverSneakers® fitness membership	\$0 copay 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 \$0 copay for non-Medicare covered podiatry visits For non-Medicare covered services, we cover up to twelve 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

Benefit	Your costs in our plan
	Non-Medicare covered home health care services are not covered.
Meal benefit (post-discharge)	\$0 copay for the meal benefit when you use our authorized vendor, NationsMarket™ After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 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.

Medical equipment and supplies

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

Benefit	Your costs in our plan
Durable medical equipment (DME), such as wheelchairs, crutches, and oxygen equipment	20% coinsurance
Prosthetics, such as braces and artificial limbs	20% coinsurance

Resources For Living®

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

Substance use disorder services

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

Benefit	Your costs in our plan
Outpatient substance use disorder services	\$10 copay for individual sessions \$10 copay for group sessions

24-Hour Nurse Line

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

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

Special supplemental benefits

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

Extra Supports Wallet	
Eligibility requirements	If you are diagnosed with one or more of the chronic conditions listed in the EOC and meet all 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	After meeting all eligibility requirements, the \$140 monthly benefit amount in the Over-the-Counter (OTC) Wallet will change to the Extra Supports Wallet with additional spending categories. Qualified members can use this wallet to help pay for certain healthy foods, over-the-counter (OTC) health and wellness products, transportation, utilities, and personal care products. This will replace your OTC Wallet. You will not get any additional funds applied to your card. Approved products can be purchased in-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at CVS.com/ Aetna, or shop by phone. Important: If you qualify, this wallet will be added to your current Aetna® Medicare Extra Benefits Card.

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include 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.

Recovery at Home Program

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

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, we're here 8 AM to 8 PM, 7 days a week. From April 1 to September 30, we're here 8 AM to 8 PM, Monday through Friday.

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** 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.
- ☐ **If you're enrolling in a plan with prescription drug coverage:** 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.
- ☐ **If you're enrolling in a plan with prescription drug coverage:** Review the formulary to make sure your drugs are covered.

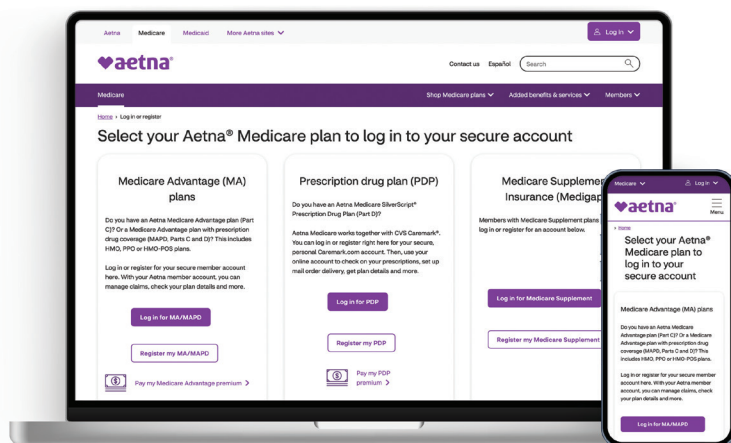
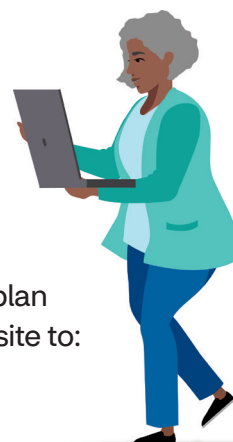
Understanding important rules

- ☐ **Effect on current coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care 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.
- ☐ **If you're enrolling in a plan with a monthly premium:** 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. The Part B premium is covered for full-dual members.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2028.
- ☐ **If you're enrolling in an HMO plan:** 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).
- ☐ **If you're enrolling in a PPO plan or other plan that offers out-of-network coverage:** 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.
- ☐ **If you're enrolling in a C-SNP plan:** 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.
- ☐ **If you're enrolling in a D-SNP plan:** This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ **If you're enrolling in an I-SNP plan:** This plan is an Institutional Special Needs Plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.

Manage your plan online

Your secure member website and Aetna HealthSM app help you understand and manage your benefits.

They're personalized to help you make the most of your plan. After receiving your plan confirmation and acceptance letter, you can register for your secure member website to:



- **View important plan documents and info**, including Summary of Benefits and Evidence of Coverage
- **See what's covered**, including wellness and support programs
- **Connect to care** — find in-network primary care doctors, specialists and other providers
- **Access your digital member ID card**, and much more

Sign up: Visit aetna.com/EGMemberLogin and use your member ID card to sign up for your secure member website.



Manage your plan anytime, on the go



Just visit aetna.com/EGHealthApp to get our app. It has the same great features as your secure member website.



Scan this secure code for more details.
Or visit AetnaMedicare.com to learn more.

How to scan a QR code

It's easy as 1-2-3

1. **Open the camera app on your smartphone.**
2. **Point your camera at the QR code.** Your camera will automatically scan the code and show a link.
3. **Tap the link.** You'll be taken to our homepage where you can easily download the Aetna Health app.





2027-18.45.304.1

Medicare Star Ratings

Plan ratings from
members, providers
and Medicare

Here's how Star Ratings work

The federal government (the Centers for Medicare & Medicaid Services, also known as CMS) uses information from member satisfaction surveys, plans and health care providers to rate Medicare Advantage plans and prescription drug plans (Part D).

Medicare Advantage plans are rated on how well they perform in these categories:

- ★ **Staying healthy (screenings, tests and vaccines)**
- ★ **Managing chronic (long-term) conditions**
- ★ **Plan responsiveness and care**
- ★ **Member complaints, problems getting services and choosing to leave the plan**
- ★ **Health plan customer service**

Each plan receives a rating from one star (lowest) to five stars (highest). Star Ratings are calculated each year and may change from one year to the next.



This is the best Medicare Advantage plan I have ever had. Everyone is so helpful. Aetna makes everything about my medical coverage easy to understand.*”

| Aetna Medicare member

*Member feedback has been edited for length and clarity; member not pictured.

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H1609

For 2026, Aetna Medicare - H1609 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★

Health Services Rating: ★★★★★

Drug Services Rating: ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Aetna Medicare 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 833-859-6031 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time. Current members please call 833-595-1008 (toll-free) or 711 (TTY).

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Sign up for your plan



By phone

Call us or a licensed sales agent to enroll over the phone or set up an in-person meeting. We're here to help you walk through your options. And help you find the plan that's right for you.



Online

Visit us online to enroll. You may also go to **Medicare.gov** to enroll in our plans through the Centers for Medicare & Medicaid Services website.



By fax

Complete and fax the enrollment form in the back of this guide to the number on the form.



By mail

Complete and mail the enrollment form in the back of this guide to the address on the form.

3 steps to enrollment

1 Submitting your application

- Apply for a C-SNP plan using one of the ways above. We'll reach out to you directly if we need any information.

2 Verifying your condition

- We'll contact your primary care provider (PCP) or specialist within 7–10 days of receiving your application.
- We'll also ask your provider to confirm you have one or more of the chronic conditions needed to be eligible for this plan. Your provider completes this confirmation form and returns it to us by email or fax.
- You can go to **AetnaMedicare.com** anytime and download the provider confirmation form. You can bring this to your provider to fill out if you choose.

3 Confirming your enrollment

- Your provider must respond by the end of your second month enrolled in the plan.
- When your provider confirms your condition(s) in this time frame, you stay enrolled in the plan.



Keep in mind

If we don't receive confirmation by the end of your second month in the plan, we must end your participation. If this happens, you'll be eligible for a Special Enrollment Period. During that time, your broker can help you enroll in another plan.



What happens next?

You'll hear from us within about 14 days of your acceptance into the plan. If we have any questions about your enrollment form, we'll call you and send a letter with details.



Plan confirmation and acceptance letter

This letter includes information to help you understand your plan's features. We'll send it to you once the Centers for Medicare & Medicaid Services approves your enrollment.

You'll get your letter in the mail.



Member ID card

This card — not your Medicare card — should be used each time you visit a provider, hospital or pharmacy (if you have prescription drug coverage).

You'll get your Aetna® Medicare member ID card in the mail.



Evidence of Coverage (EOC)

This is a complete description of coverage under your Medicare Advantage plan and your member rights.

Your EOC and other important plan documents will be available on our website in October 2026.



Use scissors to easily remove this page.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a personal marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please mark the type of product(s) you want the agent to discuss.

(Refer to page 2 for product type descriptions.)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Supplemental Health Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products marked above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. If you would like to discuss additional products not marked above, a new form must be completed. This scope of appointment is only valid for 12 months after your signature date. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature:	Signature Date:
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If you are the authorized representative, please sign above and print below:

Representative's Name:	Your Relationship to the Beneficiary:
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To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:

Agent/Plan use only

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented at least 48 hours prior to meeting:

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You'll usually pay more to see out-of-network providers.

Medicare Point of Service (POS) Plan: A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you'll be responsible for Medicare coinsurance and deductibles.

Medicare Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.

Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans aren't affiliated or connected to Medicare.

Supplemental Health Products

Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans aren't affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products

Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that aren't covered by Medicare, like care outside of the country. These plans aren't affiliated or connected to Medicare.

Scope of Appointment documentation is subject to CMS record retention requirements.

Aetna Medicare is an HMO, PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. SilverScript is a Prescription Drug Plan with a Medicare contract marketed through Aetna Medicare. Enrollment in SilverScript depends on contract renewal.

Y0001_NR_8950200_2027_C



Aetna Medicare
2027 Individual Enrollment Request Form
Instructions

How to enroll

OMB No. 0938-1378 Expires 12/31/2026

Online at: AetnaMedicare.com or through Medicare at Medicare.gov	Call us at: 1-833-771-2456 (TTY: 711)	Through your agent: Give them the completed form	Fax to: Attention: Enrollment Department Fax: 1-844-749-2651	Mail to: Aetna Medicare PO Box 14077 Lexington, KY 40512
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Get ready

Have the following handy:

- Your red, white and blue Medicare insurance card
- Your health insurance information for any other insurance you have (including Medicaid)
- If you are an Aetna Medicare member now, or have been in the past, please have your Member ID number ready to include in the "Answer these important questions" section.
- Your primary care provider's information which is available online at **AetnaMedicare.com/findprovider**

Questions?

Call us at **1-833-771-2456 (TTY: 711)**. We're here 8 AM to 8 PM, 7 days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

Tips for your enrollment request

- Each applicant must complete their own enrollment. Please don't photocopy a form for reuse.
- **Please print neatly. Complete all sections.** Don't forget to sign and date the form.
- **For individuals experiencing homelessness:** If you want to join a plan but have no permanent residence, a Post Office Box, the address of a shelter or clinic, or the address where you receive mail (for example, Social Security checks) may be considered your permanent residence address.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).
- Make a copy of the completed application for your records.
- We recommend you confirm your form was received if you fax or mail it (for example, call us to confirm receipt or send certified mail).

Thank you for choosing our plan. You'll hear from us within 10–14 days.

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Typically, you may enroll in a Medicare Advantage Plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you.

By checking any of the following boxes, you are certifying, to the best of your knowledge, that you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Prospective member name	Medicare Number ____ - ____ - ____
--------------------------------	--

Reason for Annual Enrollment Period Eligibility

- ☐ I'm enrolling **between 10/15/26 and 12/7/26** during the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

- ☐ I'm new to Medicare.
- ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on ____/____/____ (date).
- ☐ I had Medicare prior to now, but I'm now turning 65.

Reasons for Open Enrollment Period Eligibility

Between 1/1/27 and 3/31/27:

- ☐ I'm in a Medicare Advantage plan and want to make a change.

Between 4/1/27 and 12/31/27:

- ☐ I'm in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.

Reasons for Special Enrollment Period Eligibility

- ☐ I moved to a new address that's outside my current plan's service area, or I recently moved and have new options available to me. I moved on ____/____/____ (date).
- ☐ I was released from jail. I was released on ____/____/____ (date).
- ☐ I moved back to the United States after living outside the country. I returned to the U.S. on ____/____/____ (date).
- ☐ I recently got lawful presence status in the United States. I got this status on ____/____/____ (date).
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____ (date).
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)). (continued on the next page)

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Prospective member name

Medicare Number

____ - ____ - ____

Reasons for Special Enrollment Period Eligibility *(continued)*

- ☐ I recently had a change in my Extra Help paying for my drug costs (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on __/__/__ (date).
- ☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on __/__/__ (date).
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or rehabilitation hospital. I moved out of the facility on __/__/__ (date).
- ☐ I lost other, non-Medicare drug coverage (creditable coverage), or my other non-Medicare coverage changed and is no longer considered creditable coverage. I lost my drug coverage on __/__/__ (date).
- ☐ I left coverage from my employer or union (including COBRA coverage) on __/__/__ (date).
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I am losing help from a State Pharmaceutical Assistance Program.
- ☐ I lost my coverage because my plan no longer covers the area that I live.
- ☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan. I lost my coverage on __/__/__ (date).
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on __/__/__ (date).
- ☐ I lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the plan on __/__/__ (date).
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state or my local government). One of the other statements applied to me, but I was unable to make my request because of the disaster.

If none of these statements above apply to you, but you feel you have a special circumstance which allows you to enroll, you can call us at **1-833-771-2456 (TTY: 711)**. We're here 8 AM to 8 PM, 7 days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30. We can help you to determine if you qualify for a Special Election Period.

Otherwise, note the reason for your Special Election period below. Aetna may contact you to determine if you're eligible.

☐ Other SEP Reason: _____

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Enrollment Request Form

Agent Use Only:

Agent Name:

NPN#:

To enroll in an Aetna plan, please provide the following information:

Choose your plan

Check the plan you want to enroll in.

☐ *Aetna Medicare Chronic Care (HMO C-SNP) (H1609-098) **\$0.00** per month

☐ *Aetna Medicare Chronic Care (HMO C-SNP) (H1609-099) **\$0.00** per month

*Note: Plans with an asterisk (*) next to the plan name must have a Primary Care Provider (PCP) assigned. See the **Choose your Primary Care Provider (PCP)** information below.*

Proposed effective date of coverage: __ / __ / __

Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1. Aetna cannot guarantee the effective date you've requested will be honored.

Choose your Primary Care Provider (PCP)

Some of our plans coordinate your care through a PCP. We have noted these plans with an asterisk (*) next to the plan name (*Example: "Aetna Medicare Eagle (PPO)"*). If you selected a plan noted with an asterisk, and do not choose a PCP, we may not pay for your care and will assign a PCP to you. **Please note that a specialist is not considered a valid PCP selection.**

If the plan you have selected does NOT have an asterisk (*) next to the plan name, you still have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Write in the **name**, **Provider ID** and **Primary Care ID** of your primary care provider (PCP) below. Visit our online provider directory at **AetnaMedicare.com/findprovider** or call **1-833-771-2456 (TTY: 711)** to find provider information or a network PCP for your specific plan selection.

Full name of your PCP (first and last name)

Are you a current patient?

☐ Yes ☐ No

Provider ID (located in the provider directory)

--	--	--	--	--	--	--	--

Primary Care ID (located in the provider directory)

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Your information

Last name		First name		Middle initial
Birth date _ _ / _ _ / _ _ _ _ _ _ M M D D Y Y Y Y		Sex ☐ Male ☐ Female	Phone number (_ _ _) _ _ _ - _ _ _ _ Is this a mobile number? ☐ Yes ☐ No	
Email address				
Enter your <i>permanent</i> residence street address below - including Apt/Suite/Unit. Don't enter a PO Box unless you are experiencing homelessness. ☐ Check here if you are currently experiencing homelessness				
Permanent residence address				
Street address - including Apt/Suite/Unit				
City	County		State	ZIP code
<i>Mailing address</i> (if different from your permanent street address)				
Address - including Apt/Suite/Unit				
City			State	ZIP code

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Your Medicare information

This information is on your red, white and blue Medicare insurance card
You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare Number: _____ - _____ - _____	Effective Date:
	HOSPITAL (Part A) ____/____/____
	MEDICAL (Part B) ____/____/____

Answer these important questions

☐ Yes ☐ No	1. Will you have other <u>prescription</u> drug coverage in addition to Aetna Medicare? Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____												
☐ Yes ☐ No	2. Are you enrolled in your state's <u>Medicaid</u> program? If "Yes," write in your Medicaid number (please note, this is not your Social Security number):												
☐ Yes ☐ No	3. Are you a current or past Aetna Medicare member? If "Yes," write in your Aetna Member ID number (12 digits beginning with "10"): <table border="1"><tr><td>1</td><td>0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	1	0										
1	0												

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All questions below are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Indicate your **preferred spoken language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify):

Indicate your **preferred written language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify):

Select one if you want us to send you information in an accessible format:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please call us at **1-833-771-2456 (TTY: 711)** if you need information in an accessible format other than what's listed above. We're here 8 AM to 8 PM, 7 days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

Would you like to receive communications electronically instead of by mail?

We can email you when certain documents, such as your Explanation of Benefits (EOB), are ready to view online. Be sure to include your email address in the "Your information" section above. You can opt out at any time by logging into our member website at **AetnaMedicare.com**, or by calling member services using the number on your ID card. If your email address is invalid or emails cannot be delivered, we will send your documents by mail instead. Select one or more below:

☐ **Explanation of Benefits (EOB)** – a statement that shows the amount your plan paid and the amount you may owe your provider. You'll get an email whenever a document is ready to view.

☐ **Other communications** – other letters, notices and updates that you could receive in the mail. You'll get an email whenever a document is ready to view.

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Paying your plan premiums

Let us know how you want to pay your monthly plan premium (including any late enrollment penalty you may owe). Please select an option even if your plan has a \$0 premium. If you don't select a payment option, we'll automatically send you an invoice each month.

☐ **Electronic Funds Transfer (EFT) from checking or savings account**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past due payments at the time of the monthly draft.

Please complete the following:

Account holder name: _____

(Print the name as it appears on the account to be debited.)

Bank name: _____

ROUTING NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ACCOUNT NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Account type:

☐ Checking

☐ Savings

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **Automatic deduction from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

• **Do not select this option if:**

- Another program (such as an Employer Group or State Pharmaceutical Assistance Program (SPAP)) is paying part of your premium.
- You are enrolling in a plan with a \$0 premium and you do not owe a late enrollment penalty.
- You are enrolling in a Dual-Eligible Special Needs Plan (D-SNP) or an Institutional Special Needs Plan (ISNP).
- SSA/RRB will tell us when your premium deduction will start coming out of your SSA/RRB check (this could take up to 3 months). While we wait for your request to process, we'll send you an invoice to pay your premium.
- Sometimes SSA/RRB may not accept the request for deductions from your SSA/RRB check. If this happens, we'll send you an invoice to pay your monthly premium.

☐ **Monthly payments by invoice**

- You can mail us a check with your payment slip each month.
- You can go online and pay by debit or credit card after your enrollment in the plan is active.
- You can bring your invoice to any CVS Pharmacy[®] and pay with cash, credit card, or debit card. (This service is not available at CVS Pharmacy at Target[®] or Schnucks Pharmacy locations.)

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Additional notes about payment and options

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your SSA or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D-IRMAA payment to us.**
- Written EFT terminations must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due.
- If you owe a late enrollment penalty, you can pay the penalty by EFT, mail or have it taken out of your SSA or RRB benefit check.
- People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**. You can also apply for Extra Help online at **ssa.gov/medicare/part-d-extra-help**.
- If you qualify for Extra Help with your Medicare prescription drug costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Read this important information and sign below

- **If you currently have health coverage from an employer or union, joining Aetna Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
- I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Medicare.
- By joining this Medicare Advantage plan, I acknowledge that Aetna Medicare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on the next page).

PRIVACY ACT STATEMENT

- The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-For-Service (PFFS), MA Medical Savings Account (MSA) plans).

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- **MA-only plans:** I understand that when my Aetna Medicare coverage begins, I must get all of my medical benefits from Aetna Medicare. **MA-PD plans:** I understand that when my Aetna Medicare coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare. **All plans:** Benefits and services provided by Aetna Medicare and contained in my Aetna Medicare “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Medicare will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:

- 1) this person is authorized under State law to complete this enrollment, and
- 2) documentation of this authority is available upon request from Medicare.

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. Plan features and availability may vary by service area. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Signature	Today's date ____/____/____
------------------	---------------------------------------

If you're an **authorized representative (such as a power of attorney)** filling out this form on behalf of the enrollee, you must sign above and provide the following information. **Note: Broker or agent may not sign for enrollee.**

Name	Address
Phone number (____) ____ - ____	Relationship to enrollee

For individuals helping an enrollee with completing this form

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping someone fill out this form (but not authorized to make decisions on behalf of the enrollee).

Name	Relationship to enrollee
Signature	National Producer Number (NPN) (Agents/Brokers only)

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According to the Paperwork Reduction Act (PRA) of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "How to enroll" on the first page of this form to send your completed form to the plan.

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Aetna® Medicare Prequalification Assessment Tool

IMPORTANT: You are enrolling in an Aetna Medicare Chronic Condition Special Needs Plan (C-SNP).

Our C-SNP is for people who have diabetes, congestive heart failure and certain cardiovascular disorders. Before we can enroll you in a C-SNP, we are required by the Centers for Medicare & Medicaid Services (CMS) to confirm with your provider that you have one of these conditions.

This is a two-step process.

Step 1: Please fill out this form. Return it with your completed enrollment application. If you check the box for at least one condition, you may qualify for an Aetna Medicare C-SNP.

Step 2: We will confirm your qualifying condition within 30 days of your enrollment with your physician.

Note: Without provider verification of chronic condition(s) within 60 days of enrollment, you will be involuntarily disenrolled from the plan.

Read the following statements carefully and check the box of the condition that applies to you.

By checking a box, you certify that you have one of the covered chronic condition(s) required to join this type of plan. If we later determine that this information is incorrect, you may be disenrolled.

Applicant's chronic condition diagnosis (check at least one box below):

Has a provider ever diagnosed you with one or more of the following conditions?

☐ Diabetes mellitus: (high blood sugar)	☐ Chronic heart failure (CHF) (heart is unable to pump blood as it should)	Cardiovascular disease: ☐ Cardiac arrhythmias (irregular heartbeats) ☐ Coronary artery disease (blocked blood vessels in the heart) ☐ Peripheral vascular disease (poor circulation in the arms and legs) ☐ Valvular heart disease (damage of flaps in the heart that control blood flow)
☐ I do not have any of these conditions.		

Use and disclosure authorization

Completion of this form authorizes the disclosure of individually identifiable health information in accordance with federal laws concerning the privacy of such information.

By providing your signature below, you certify that you have been diagnosed with one or more of the chronic conditions necessary for enrollment in an Aetna Medicare Chronic Condition Special Needs Plan.

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Applicant/Authorized representative — please complete all fields as applicable.

Applicant name (required):	Date of birth (required): ___/___/_____
Medicare number (required): _____ - _____ - _____	Telephone number (required): (____) _____ - _____
Signature (required):	Today's date: ___/___/_____

If you are an authorized representative helping someone fill out this form, you must sign above and provide the information below.

Name:	Relationship to applicant:
Address:	Telephone number (required): (____) _____ - _____

Please provide the name of the provider(s) who can confirm your diagnosis below.

Provider #1 who can verify your chronic condition — (required)

Physician/Nurse practitioner/Physician assistant name (required):																				
Office telephone number (required): (____) _____ - _____	Office fax number: (____) _____ - _____																			
National Provider Identifier (NPI) (located in the provider directory):	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																			
Address line 1																				
Address line 2																				
City	State	ZIP code																		
Office email address:																				

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Provider #2 who can verify your chronic condition (optional)

Physician/Nurse practitioner/Physician assistant name:												
Office telephone number: (____) ____ - ____	Office fax number: (____) ____ - ____											
National Provider Identifier (NPI) (located in the provider directory):	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>											
Address line 1												
Address line 2												
City	State	ZIP code										
Office email address:												

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.

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AGENT USE ONLY

Agent/producer/broker/representative must complete this section

Applicant's name

If you are the agent/producer/broker/employed sales representative, you must provide the following information and submit it with the completed application.

☐ Yes ☐ No Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.)

If "No," why not? :

☐ Yes ☐ No Was the SOA captured electronically or by telephone?

If "Yes," please provide the confirmation/ID number:

Attach the SOA or indicate why it's not available:

Name of agent/producer/broker/sales rep:

Phone number:

National Producer Number (NPN):

☐ Check box if application received at a retail kiosk.

NOTE: If the agent/producer/broker/employed sales representative takes receipt of this application, a signature and date are REQUIRED below. Your signature indicates you understand that this application must be submitted within two calendar days of this date.

Signature of agent/producer/broker/sales rep:

Date agent received the Individual Enrollment Request Form:

Copy and keep this completed form for your records. The completed election period checklist on page 1 must be included with the form.

Fax or mail the completed form to:
Aetna Medicare
PO Box 14077 Lexington, KY 40512
Fax: 1-844-749-2651

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Medicare Advantage Plan Enrollment Receipt

Agent/Broker: Complete and leave with enrollee.

Keep this as proof of your enrollment request until Medicare has confirmed your enrollment and you receive your member materials. This receipt is not a guarantee of enrollment.

This receipt is for your records only. No further action is necessary.

Applicant

Name:

Today's Date:

Proposed Effective Date:

Call your Agent/Broker if you have any questions

Agent/Broker Name:

Agent/Broker Phone Number:

Agent/Broker ID:

If you would like a complete copy of your enrollment form, call us at **1-800-562-6315 (TTY: 711)**, 8 AM to 8 PM, 7 days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30. Please allow at least 3 business days for us to process your application. **You'll need to provide your application tracking number, located at the bottom of this page.**

Reminder - Your enrollment request is for a **Medicare Advantage plan (Part C)**. These plans:

- Replace Original Medicare that's provided by the federal government.
- Cover all your Part A and Part B benefits.
- Don't supplement your Original Medicare coverage like Medicare Supplement or Medigap plans.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Our D-SNPs also have contracts with State Medicaid programs. Plan features and availability may vary by service area. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Application Tracking Number:

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Aetna®, CVS Caremark® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Aetna Medicare is an HMO, PPO plan with a Medicare contract. Our D-SNPs 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 health care provider that you have one of these eligible conditions. If verification of eligible condition is not received, involuntary disenrollment will occur.

Every year, Medicare evaluates plans based on a 5-Star rating system.

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 the phone number on your member ID card if you do not receive your mail-order drugs within this time frame. Members may have the option to sign up for automated mail-order delivery.

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/pharmacyhelp**.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Other pharmacies/physicians/providers are available in our network.

Plan features and availability may vary by service area.

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.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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This material is for informational purposes only and is not medical advice. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Contact a health care professional with any questions or concerns about specific health care needs. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna is not a provider of health care services and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to our website.

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.

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

Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on this document. (English)

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

للحصول على خدمات اللغة مجانًا، اتصل بالرقم المذكور في هذه الوثيقة. (Arabic)

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa doookumentii kanarra jiru irratti bilbilaa. (Cushite)

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

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

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

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)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato in questo documento. (Italian)

無料の言語サービスをご利用いただくには、この書類に記載されている番号にお電話ください。 (Japanese)

လၢကမၤန့ၣ် ကျိၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢၣ်ဘျၣ်လၢၣ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလၢၣ်တီၢ်လၢၣ်မိအံၤအဖီခိၣ်န့ၣ်တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, ໃຫ້ໂທຫາເບີໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian)

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Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)

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Here's to your
best health!





We're so glad you're here!

We created this guide to make it easier to connect with your Aetna® Medicare plan.

In these pages, you'll have the info you need, right at your fingertips.

You'll learn how to:

- Enroll in the plan that's right for you
- Access your plan details
- Sign up for your secure member website
- Get the Aetna HealthSM app
- Find the answers you need, when you need them, and much more

Want to learn more?

Just flip this guide over
to get the whole story.

