



2026

**Medicare benefits
and information guide**



**Healthier
happens together[®]**



**Aetna MedicareSM Plan (PPO)
with prescription drug coverage**

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Welcome



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Turn the page
to learn more.





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.

Aetna Medicare Advantage with prescription drug coverage

A plan with prescription drug benefits can help cover the cost of your medicine.

What is Medicare Advantage?

If you've never had a Medicare Advantage plan before, you may have questions about what it covers or how it compares to other Medicare plans. To learn more, visit:

AetnaRetireePlans.com

You're covered from the provider's office to the pharmacy

Our all-in-one Aetna® plan combines medical benefits with prescription drug coverage. So you'll have just one plan and member ID card for your medical and prescription drug needs.



See if your prescriptions are covered

Our plan covers many of the most commonly prescribed generic and brand-name drugs.

To find your medicine in our formulary (drug list):

- Go to **AetnaRetireePlans.com**
- Follow the prescription drug list search instructions

No computer or internet? No worries.

Call us at **1-800-307-4830 (TTY:711)**.



Pharmacy coverage from coast to coast

Our pharmacy network includes national chains and local options.



Find a network pharmacy close to you



Search online.

To view locations in your area, visit:
[AetnaRetireePlans.com](https://www.aetna.com/retireeplans)



Ask an Aetna® representative.

Call **1-800-307-4830 (TTY:711)**.

We're here
8 a.m. to 9 p.m. EST, Monday through Friday.



Home delivery

With CVS Caremark® Mail Service Pharmacy, our preferred mail-order pharmacy, standard shipping is always free. Your medicine is checked for accuracy by a registered pharmacist and mailed quickly and safely to you.

If you have questions about your medicine, you can call anytime.



Medicare 101

Understand how
your plan works

About your plan



Aetna MedicareSM Plan (PPO ESA)

The Aetna Medicare Advantage PPO Extended Service Area (ESA) plan stands out from other health care plans. You have access to in-network providers such as doctors, hospitals and labs. And you also have access to out-of-network providers — at no added cost — if the provider is:

- Eligible to receive payment under Medicare, and
- Agrees to bill and accept payment from Aetna®

Does your provider accept our plan? They most likely will. That's because more than **1.1 million network providers and specialists** and over **4,200 network hospitals** accept the Aetna Medicare plan.

With this plan, you'll have the option to choose a primary care provider (PCP). It's not required, but when we know who your provider is, we can better support your care.



To find out if your provider accepts the plan, just call us. We're available at **1-800-307-4830 (TTY:711)**.

8 a.m. to 9 p.m. EST, Monday through Friday.

We'll contact your provider to confirm. We can also help you find other nearby providers and hospitals who accept the plan.

Summary of Benefits

Take a look
at your plan



18.00.106.1-ESA

Aetna MedicareSM Plan (PPO ESA)

The **Summary of Benefits** shows expected costs for services and describes the benefits package. These details affect what you'll pay for your care. So be sure to review all the pages in this section.

More than one plan may be available to you.





Benefits and Premiums are effective January 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No
Annual Deductible	\$100
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Services Exempt from Deductible: Annual wellness exams, routine physical exam, routine mammograms, diagnostic mammogram, routine hearing exam, routine colorectal screening, routine prostate screening, bone mass measurement, immunization, routine GYN, routine eye care, kidney disease education, Medicare diabetic prevention program (MDPP), Medicare-covered \$0 preventive services, additional Medicare preventive care services, Part B Drugs - Insulin, Continuous Glucose Monitors (CGMs), emergency room, emergency ambulance services, some Medicare-covered diagnostic tests and labs (Urine protein, Prothrombin testing, HBA1C, FIT Screening, Fundus Testing, gFOBT Testing and COVID lab tests), Wigs, Teladoc, and urgently needed care.	
Annual Maximum Out-of-Pocket Amount	



Annual maximum out-of-pocket limit amount \$2,000
includes any deductible, copayment or
coinsurance that you pay.

It will apply to all medical expenses except Hearing Aid Reimbursement , Vision Reimbursement that
may be available on your plan.

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
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Inpatient Hospital Care	\$0 per stay
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The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay

Outpatient Services & Surgery	\$0
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Ambulatory Surgery Center	\$0
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PHYSICIAN SERVICES	This is what you pay for network & out-of-network providers.
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Primary Care Physician Visits	\$20
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Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.

Physician Specialist Visits	\$20
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PREVENTIVE CARE	This is what you pay for network & out-of-network providers.
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Medicare-covered Preventive Services	\$0
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- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings and counseling
- Annual Well Visit - One exam every 12 months.
- Bone mass measurements
- Breast exams
- Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
- Cardiovascular behavior therapy
- Cardiovascular disease screenings
- Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.



- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
 - Depression screenings
 - Diabetes screenings
 - HBV infection screening
 - Hepatitis C screening tests
 - HIV screenings
 - Lung cancer screenings and counseling
 - Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
 - Nutrition therapy services
 - Obesity behavior therapy
 - Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
 - Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
 - Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
 - Sexually transmitted infections screenings and counseling
 - Tobacco use cessation counseling
 - Welcome to Medicare preventive visit
-

Immunizations \$0

- Flu
 - Hepatitis B
 - Pneumococcal
-

Additional Medicare Preventive Services \$0

- Diabetes self-management training (DSMT)
- Digital rectal exam (DRE)
- EKG following welcome exam
- Glaucoma screening



EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network & out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	\$50
Urgently Needed Care; Worldwide	\$20
DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology CT scans	\$20
Diagnostic Radiology Other than CT scans	\$20
Lab Services	\$0
Diagnostic testing & procedures	\$0
Outpatient X-rays	\$20
HEARING SERVICES	This is what you pay for network & out-of-network providers.
Routine Hearing Screening We cover one exam every twelve months	\$0
Medicare Covered Hearing Examination	\$20
Hearing Aid Reimbursement	\$2,000 once every 36 months
DENTAL SERVICES	This is what you pay for network & out-of-network providers.
Medicare Covered Dental* Non-routine care covered by Medicare.	\$20
VISION SERVICES	This is what you pay for network & out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	\$0
Diabetic Eye Exams	\$0
Medicare Covered Eye Exam	\$20
Vision Eyewear Reimbursement Applies to in or out of network	\$250 once every 24 months



MENTAL HEALTH SERVICES*		This is what you pay for network & out-of-network providers.
Inpatient Mental Health Care		\$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care		\$20
Individual visit		
Partial Hospitalization		\$20
Intensive Outpatient Services		\$20
Inpatient Substance Abuse		\$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse		\$20
Individual visit		
SKILLED NURSING SERVICES*		This is what you pay for network & out-of-network providers.
Skilled Nursing Facility (SNF) Care		\$0 per day, days 1-100
Limited to 100 days per Medicare Benefit Period.		
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.		
PHYSICAL THERAPY SERVICES*		This is what you pay for network & out-of-network providers.
Outpatient Rehabilitation Services		\$20
(Speech, physical, and occupational therapy)		
AMBULANCE SERVICES		This is what you pay for network & out-of-network providers.
Ambulance Services		\$20
Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.		



FRATERNAL ORDER OF POLICE LODGE #7 CHICAGO

Aetna MedicareSM Plan (PPO)

Option 2 -(S01) ESA PPO

TRANSPORTATION SERVICES		This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	24 one-way trips with unlimited miles allowed per trip	
MEDICARE PART B PRESCRIPTION DRUGS*		This is what you pay for network & out-of-network providers.
Medicare Part B Prescription Drugs	\$0	
Medicare Part B Prescription Drugs - Insulin	\$0	



ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	\$0
Allergy Testing	\$20
Blood	\$0
All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	\$20
Intensive Cardiac Rehabilitation Services	\$20
Chiropractic Services*	\$15
Medicare covered benefits only.	
Diabetic Supplies*	\$0
Includes supplies to monitor your blood glucose.	
Durable Medical Equipment/ Prosthetic Devices*	20%
Home Health Agency Care*	\$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	\$20
Outpatient Dialysis Treatments*	\$20
Podiatry Services	\$20
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	\$20
Supervised Exercise Therapy (SET) for PAD Services	\$20
Radiation Therapy*	\$20
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers®
Healthy Rewards	Covered
Meals	\$0
Covered up to 14 meals following an inpatient stay.	



Resources For Living[®]	Covered
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For help locating resources for every day needs.

Smoking and Tobacco Use Cessation Supplies	\$0
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Frequency	unlimited visits every year
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Teladoc[™]	\$0
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Telemedicine services with a Teladoc[™] provider. State mandates may apply.

Telehealth	Covered
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Telemedicine Services. Member cost share will apply based on services rendered.

Telehealth PCP	\$20
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Telehealth Specialist	\$20
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Telehealth Occupational Therapy Services	\$20
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Telehealth PT and SP Services	\$20
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Telehealth Other Health care Providers	\$20
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Telehealth Individual Mental Health	\$20
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Telehealth Group Mental Health	\$20
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Telehealth Individual Psychiatric Services	\$20
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Telehealth Group Psychiatric Services	\$20
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Telehealth Individual Substance Abuse Services	\$20
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Telehealth Group Substance Abuse Services	\$20
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Telehealth Kidney Disease Education Services	\$0
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Telehealth Diabetes Self-Management Training	\$0
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Telehealth Opioid Treatment Program Services	\$20
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Telehealth Urgent care	\$20
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Wigs*	\$0
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Maximum	\$400
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Frequency	every year
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**ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)****This is what you pay for network & out-of-network providers.****Routine Physical Exams**

\$0

One exam per calendar year

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

For more information about Aetna plans, go to [AetnaRetireePlans.com](https://www.aetna.com/retireeplans) or call Member Services toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Medical Disclaimers

The provider network may change at any time. You will receive notice when necessary.

Participating physicians, hospitals and other 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.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the Evidence of Coverage (EOC). You can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is



recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna 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.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Plan Disclaimers

Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna).

Participating physicians, hospitals and other 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.

To join the Aetna Medicare Advantage Plan Open Access PPO , you must meet the requirements of the plan sponsor/your former employer, be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

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.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are



available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711).

Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at <http://www.aetnaretireeplans.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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Approved By:

Date:



Benefits and Premiums are effective January 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

PLAN FEATURES	Network & out-of-network providers.
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Plan Follows the Federal Medicare Part B Deductible Plan deductible is equal to the Federal Medicare Part B deductible	No
Annual Deductible	\$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	
Annual maximum out-of-pocket limit amount \$0 includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement , Vision Reimbursement that may be available on your plan.	



HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care	\$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Stay	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay
Outpatient Services & Surgery	\$0
Ambulatory Surgery Center	\$0
PHYSICIAN SERVICES	This is what you pay for network & out-of-network providers.
Primary Care Physician Visits	\$0
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	\$0
PREVENTIVE CARE	This is what you pay for network & out-of-network providers.
Medicare-covered Preventive Services	\$0
<ul style="list-style-type: none">• Abdominal aortic aneurysm screenings• Alcohol misuse screenings and counseling• Annual Well Visit - One exam every 12 months.• Bone mass measurements• Breast exams• Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.• Cardiovascular behavior therapy• Cardiovascular disease screenings• Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)• Depression screenings• Diabetes screenings• HBV infection screening	



- Hepatitis C screening tests
- HIV screenings
- Lung cancer screenings and counseling
- Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
- Nutrition therapy services
- Obesity behavior therapy
- Pelvic Exams and pap test (screening) - one routine GYN visit and pap smear every 24 months.
- Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
- Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit

Immunizations	\$0
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- Flu
- Hepatitis B
- Pneumococcal

Additional Medicare Preventive Services	\$0
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- Diabetes self-management training (DSMT)
- Digital rectal exam (DRE)
- EKG following welcome exam
- Glaucoma screening

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network & out-of-network providers.
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Emergency Care; Worldwide (waived if admitted)	\$0
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Urgently Needed Care; Worldwide	\$0
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DIAGNOSTIC PROCEDURES*	This is what you pay for network & out-of-network providers.
Diagnostic Radiology CT scans	\$0
Diagnostic Radiology Other than CT scans	\$0
Lab Services	\$0
Diagnostic testing & procedures	\$0
Outpatient X-rays	\$0
HEARING SERVICES	This is what you pay for network & out-of-network providers.
Routine Hearing Screening We cover one exam every twelve months	\$0
Medicare Covered Hearing Examination	\$0
Hearing Aid Reimbursement	\$2,000 once every 36 months
DENTAL SERVICES	This is what you pay for network & out-of-network providers.
Medicare Covered Dental* Non-routine care covered by Medicare.	\$0
VISION SERVICES	This is what you pay for network & out-of-network providers.
Routine Eye Exams One annual exam every 12 months.	\$0
Diabetic Eye Exams	\$0
Medicare Covered Eye Exam	\$0
Vision Eyewear Reimbursement Applies to in or out of network	\$250 once every 24 months



MENTAL HEALTH SERVICES*		This is what you pay for network & out-of-network providers.
Inpatient Mental Health Care		\$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care		\$0
Individual visit		
Partial Hospitalization		\$0
Intensive Outpatient Services		\$0
Inpatient Substance Abuse		\$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse		\$0
Individual visit		
SKILLED NURSING SERVICES*		This is what you pay for network & out-of-network providers.
Skilled Nursing Facility (SNF) Care		\$0 per day, days 1-100
Limited to 100 days per Medicare Benefit Period.		
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.		
PHYSICAL THERAPY SERVICES*		This is what you pay for network & out-of-network providers.
Outpatient Rehabilitation Services		\$0
(Speech, physical, and occupational therapy)		
AMBULANCE SERVICES		This is what you pay for network & out-of-network providers.
Ambulance Services		\$0
Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.		



TRANSPORTATION SERVICES		This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	24 one-way trips with unlimited miles allowed per trip	
MEDICARE PART B PRESCRIPTION DRUGS*		This is what you pay for network & out-of-network providers.
Medicare Part B Prescription Drugs	\$0	
Medicare Part B Prescription Drugs - Insulin	\$0	



ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	\$0
Allergy Testing	\$0
Blood	\$0
All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	\$0
Intensive Cardiac Rehabilitation Services	\$0
Chiropractic Services*	\$0
Medicare covered benefits only.	
Diabetic Supplies*	\$0
Includes supplies to monitor your blood glucose.	
Durable Medical Equipment/ Prosthetic Devices*	\$0
Home Health Agency Care*	\$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	\$0
Outpatient Dialysis Treatments*	\$0
Podiatry Services	\$0
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	\$0
Supervised Exercise Therapy (SET) for PAD Services	\$0
Radiation Therapy*	\$0
ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers®
Healthy Rewards	Covered
Meals	\$0
Covered up to 14 meals following an inpatient stay.	



Resources For Living® Covered

For help locating resources for every day needs.

Smoking and Tobacco Use Cessation Supplies \$0

Frequency unlimited visits every year

Teladoc™ \$0

Telemedicine services with a Teladoc™ provider. State mandates may apply.

Telehealth Covered

Telemedicine Services. Member cost share will apply based on services rendered.

Telehealth PCP \$0

Telehealth Specialist \$0

Telehealth Occupational Therapy Services \$0

Telehealth PT and SP Services \$0

Telehealth Other Health care Providers \$0

Telehealth Individual Mental Health \$0

Telehealth Group Mental Health \$0

Telehealth Individual Psychiatric Services \$0

Telehealth Group Psychiatric Services \$0

Telehealth Individual Substance Abuse Services \$0

Telehealth Group Substance Abuse Services \$0

Telehealth Kidney Disease Education Services \$0

Telehealth Diabetes Self-Management Training \$0

Telehealth Opioid Treatment Program Services \$0

Telehealth Urgent care \$0

Wigs* \$0

Maximum \$400

Frequency every year

**ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)****This is what you pay for network & out-of-network providers.****Routine Physical Exams**

\$0

One exam per calendar year

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

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- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is



recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna 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.

Aetna will pay any non contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Plan Disclaimers

Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna).

Participating physicians, hospitals and other 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.

To join the Aetna Medicare Advantage Plan Open Access PPO , you must meet the requirements of the plan sponsor/your former employer, be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

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.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are



available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711).

Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at <http://www.aetnaretireeplans.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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Y0001_GRP_1099_3731a_2021_M

Approved By:

Date:

Benefits and Premiums are effective January 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY SILVERSCRIPT INSURANCE COMPANY

PHARMACY - PRESCRIPTION DRUG BENEFITS

Monthly Premium Please contact your former employer/union/trust for more information on your plan premium.

Pharmacy Network P1

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (<http://www.aetnaretireeplans.com>.)

Formulary (Drug List) Classic

Your cost for generic drugs is usually lower than your cost for brand drugs. However, some higher cost generic drugs are combined on brand tiers.

Calendar-Year Deductible for Prescription Drugs \$100

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

4 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
Tier 1 - Generic Generic Drugs	\$6	\$18	\$18	\$18	\$18
Tier 2 - Preferred Brand Includes some high-cost generic and preferred brand drugs	\$24	\$24	\$70	\$70	\$70

4 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	Standard	Preferred Retail	Preferred Mail	Standard Retail or Mail
Tier 3 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	\$29	\$29	\$85	\$85	\$85
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	\$29	\$29	Limited to one-month supply	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than \$35 for a one-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage:

You pay \$0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of \$2,100 for covered Part D prescription drugs is reached.

Requirements:

Precertification

Applies

Step-Therapy

Applies

Non-Part D Supplemental Benefit

- Agents used for cosmetic purposes or hair growth

- Agents used to promote fertility
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Agents when used for weight loss
- Miscellaneous agents
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

For more information about Aetna Medicare Rx offered by SilverScript plans, go to [AetnaRetireePlans.com](https://www.aetna.com/retireeplans) or call Member Services toll-free at 1-800-594-9390 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Pharmacy Disclaimers

Aetna Medicare Rx offered by SilverScript's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna Medicare Rx offered by SilverScript based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

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

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-855-222-6857, 24 hours a day, 7 days a week. TTY users call 711.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the enhanced drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

Plan Disclaimers

Aetna Medicare Rx offered by SilverScript is a group standalone Medicare Prescription Drug Plan (PDP). This Plan is offered by SilverScript Insurance Company, which has a Medicare contract. SilverScript Insurance Company and Aetna are affiliated companies. Enrollment in the Plan depends on Medicare contract renewal.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-594-9390 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-594-9390 (TTY: 711).

Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-594-9390 (TTY: 711).

You can also visit our website at <http://www.aetnaretireeplans.com>. As a reminder, our website has the most up-to-date information about our pharmacy network (Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

*****This is the end of this plan benefit summary*****

Y0080_GRP_1099_3733a_2021_M

Approved By:

Date:

Here's how Star Ratings work

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



Medicare plan 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 providers and hospitals that work with the plan

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.



How to find your plan's Star Rating

- 1 Find the state you live in within the chart on the following page.
- 2 Note the contract number next to the name of your state.
- 3 Flip to the page in this section with the same contract number in the upper-left corner.
- 4 Review the overall rating for your plan.



Turn the page to see how highly our plans rate.



If you have an Aetna® Medicare plan **without** drug coverage, review just the health plan rating. You can ignore the plan's drug rating.

Aetna MedicareSM Plan (PPO)

State	Contract number
Alabama	H5522
Alaska	H5522
Arizona	H5522
Arkansas	H1608, H5522
California	H5522
Colorado	H5522
Connecticut	H5522
Delaware	H5522
District of Columbia	H5522
Florida	H5522
Georgia	H1608, H3288, H5522
Hawaii	H5522
Idaho	H5522, H9431
Illinois	H1608, H5522, H7301
Indiana	H5522
Iowa	H1608, H5522
Kansas	H1608, H5522
Kentucky	H5522
Louisiana	H5522
Maine	H5522
Maryland	H5522
Massachusetts	H5522
Michigan	H5522
Minnesota	H5522
Mississippi	H5522

State	Contract number
Missouri	H1608, H5522
Montana	H5522
Nebraska	H1608, H5522
Nevada	H5522
New Hampshire	H5522, H9431
New Jersey	H5522
New Mexico	H5522, H9431
New York	H5522
North Carolina	H5522
North Dakota	H5522
Ohio	H1608, H5522
Oklahoma	H3288, H5522
Oregon	H5522, H9431
Pennsylvania	H5522
Rhode Island	H5522, H9431
South Carolina	H5522
South Dakota	H1608, H5522
Tennessee	H5522
Texas	H3288, H5522
Utah	H5522
Vermont	H5522
Virginia	H5522
Washington	H5522
West Virginia	H1608, H5522
Wisconsin	H5522
Wyoming	H5522

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H1608

For 2025, Aetna Medicare - H1608 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

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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_GRP_2025_H1608_M

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H3288

For 2025, Aetna Medicare - H3288 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_GRP_2025_H3288_M

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H5521

For 2025, Aetna Medicare - H5521 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_GRP_2025_H5521_M

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H5522

For 2025, Aetna Medicare - H5522 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_GRP_2025_H5522_M

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H7301

For 2025, Aetna Medicare - H7301 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_GRP_2025_H7301_M

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Aetna Medicare - H9431

For 2025, Aetna Medicare - H9431 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Y0001_GRP_2025_H9431_M

After enrollment

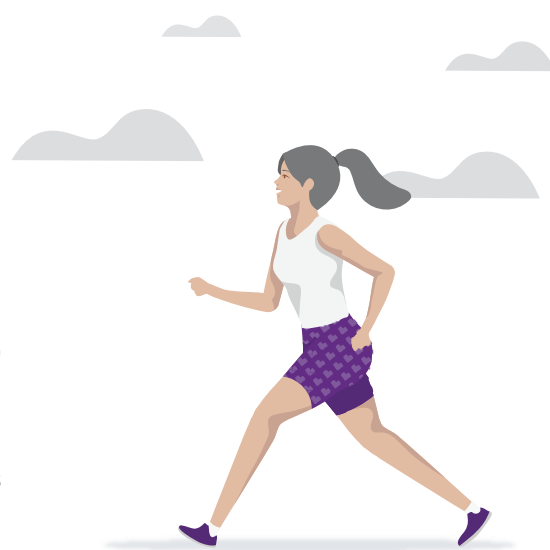
See what
happens next



18.00013011_G

What happens next

You'll hear from us within about 30 days after you enroll in the plan. Here's what you can expect:



Plan confirmation and acceptance letter

This includes info about your plan's features. We'll send it to you once the Centers for Medicare & Medicaid Services (CMS) approves your enrollment. **You'll get your letter by mail.**



Plan member ID card

This card — not your red, white and blue Medicare card — should be used each time you visit the doctor, hospital or pharmacy. **You'll get your member ID card by mail. You can also find it online.**



Evidence of Coverage (EOC)

This is a complete description of your Medicare plan coverage and your member rights. **You'll find your EOC online.**



Formulary

This is a list of drugs your plan covers and any special requirements. **You'll find your formulary online.**



Schedule of Cost Sharing (SOC)

This outlines costs that you pay out of your own pocket. This can include deductibles, coinsurance, copayments or similar charges. **Depending on your plan, you'll either get your SOC in the mail or receive instructions to find it online.**



Healthy Home Visit

We'll call you to schedule a Healthy Home Visit. You'll get in-home advice from a licensed health care professional on how to reach your health goals.

Quick tip:

Once you receive your plan member ID card, be sure to register for your secure member website. There, you can provide your email address and opt in to get important updates from us right in your inbox.

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. Enrollment in our plans depends on contract renewal.

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 **1-888-267-2637 (TTY: 711)**, 8 AM to 9 PM ET, Monday through Friday, 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: Suburban Arizona, Urban Kansas, Urban Missouri, Rural Michigan, Rural Nebraska, Rural North Dakota, Suburban West Virginia and Suburban Puerto Rico. 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 **1-855-338-7027 (TTY: 711)** or consult the online pharmacy directory at **[AetnaMedicare.com/pharmacyhelp](https://www.AetnaMedicare.com/pharmacyhelp)**.

Out-of-network/non-contracted providers are under no obligation to treat Aetna® 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.

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

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.

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.

Other Pharmacies/Physicians/Providers are available in our network.

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** (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.

Teladoc® is not available to all members. Teladoc and Teladoc physicians are independent contractors and are not agents of Aetna. Visit **[Teladoc.com/Aetna](https://www.Teladoc.com/Aetna)** for a complete description of the limitations of Teladoc services. Teladoc, Teladoc Health and the Teladoc Health logo are registered trademarks of Teladoc Health, Inc.

Important information about your enrollment in a Medicare plan

As an Aetna Medicare member, you agree to the following:

Aetna Medicare is a Medicare plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B and continue to pay my Part B premium. I can only be in one Medicare plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform Aetna of any prescription drug coverage that I have or may get in the future.

I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the (entire) year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, during the Annual Enrollment Period, which is October 15 through December 7 of every year), or under certain special circumstances.

The Aetna Medicare plan serves a specific service area. If I move out of the area that the Aetna Medicare plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I am a member of the Aetna Medicare plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare plan when I get it to know which rules I must follow to get coverage with this Medicare plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

HMO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, I must get all my health care from the Aetna Medicare plan, except for emergency or urgently needed services or out of area dialysis services.

Services authorized by the Aetna Medicare plan and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

PPO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization when required by the plan, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

I understand that beginning on the date the Aetna Medicare plan coverage begins, I must get all of my health care from Aetna Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the Aetna Medicare plan and other services contained in my Aetna Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with the Aetna Medicare plan, he/she may be paid based on my enrollment in the Aetna Medicare plan.

Release of information

By joining this Medicare health plan, I acknowledge that the Aetna Medicare plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Aetna Medicare plan will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be disenrolled from the plan.

Aetna Resources For LivingSM is the brand name used for products and services offered through the Aetna group of companies (Aetna). The EAP is administered by Aetna Behavioral Health, LLC, and in California for Knox-Keene plans, and Health and Human Resources Center, Inc.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Specialty, and OMNI Care long-term pharmacies.

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 مجاناً، 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 လၢတလိၣ်လၢၣ်ဘျီလၢၣ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလၢၣ်တီလၢၣ်မိအံၤအဖီခိၣ်န့ၣ်တက့ၢ်. (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)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

Ligue para o número indicado neste documento para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que aparece en este documento. (Spanish)

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa dokumentong ito. (Tagalog)

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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GOOD TO KNOW

Avoid late enrollment fees

It's important to sign up for Medicare coverage during your **Initial Enrollment Period**. If you don't, the federal government may charge you an extra amount (late enrollment penalty).

These penalties aren't just a one-time late fee. They're added to your monthly premium for as long as you have coverage.

For details about how to avoid late fees, be sure to visit:

[Medicare.gov/basics/costs/medicare-costs/avoid-penalties](https://www.medicare.gov/basics/costs/medicare-costs/avoid-penalties)

Important contacts



Primary care provider

Name: _____

Phone: _____



Specialists

Name: _____

Phone: _____

Name: _____

Phone: _____



Other health care professionals

Name: _____

Phone: _____



Emergency contacts

Name: _____

Phone: _____

Name: _____

Phone: _____



Pharmacy

Name: _____

Phone: _____

Address: _____



Hospital

Name: _____

Phone: _____

Address: _____



Notes:



In case of emergency, call 911.



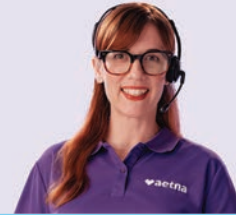
Helpful resources

Keep these handy so you can refer back to them at any time.



Call us

We're available at **1-800-307-4830 (TTY:711)**.
We're here 8 a.m. to 9 p.m. EST, Monday through Friday.



Get info online

- Want more details about the plan and additional wellness programs?
Looking for a provider or hospital?



Visit your plan website to find all that and more.
AetnaRetireePlans.com

← **Or just scan the QR code.**

- Visit **Medicare.gov** for more information about how Medicare works.

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 your plan info.



Download the Aetna HealthSM app

Manage your plan the easy way with the Aetna Health app.

a

- View claims
- Track spending
- Access your digital member ID card, and much more

Don't have the app? Get it today:



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Google Play is a trademark of Google LLC.



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:

- ✓ Access your plan details
- ✓ Sign up for your secure member website
- ✓ Get the Aetna HealthSM app
- ✓ Register online to opt in for emails to stay up to date and to receive info from us
- ✓ 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.

