D-SNP
2026

Healthier happens together®

Aetna® Medicare benefits and enrollment guide

MI D-SNP COORDINATED FULL DUAL

PLANS:
Aetna Medicare Full Dual Care (HMO D-SNP) - H3192-007

AetnaMedicare.com
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aetna®

Table of contents

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 Full Dual Care (HMO D-SNP) (H3192-007)

Michigan: Allegan, Antrim, Arenac, Bay, Benzie, Charlevoix, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Jackson, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mason, Mecosta, Missaukee, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw, Wexford

MP26-MIS02.1

For more information, see the **Summary of Benefits**.
Or call us at **1-833-859-6031 (TTY: 711)**.

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.

2026-18.45.301.1-SNP

Get started

What to consider before choosing your plan

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.

We're here to help you choose

Get the coverage you need, plus other benefits

To get the right coverage for you, there are a few things to consider.

- **Check out the plan's network.**
  - **See if your providers are in the plan's network.** In general, you'll pay $0 when you visit these providers. But if you have a copay, you'll pay less when you stay in network.
  - 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.
  - **Find out if your plan has a deductible**. This is the amount you may have to pay out of pocket for covered services or prescription drugs before your plan starts to pay. It resets at the beginning of each plan year.
- **Look at your prescriptions:**
  - **Find your medication in the plan's formulary (drug list).** This list includes common generic and brand-name drugs your plan covers.
  - **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.

    Keep in mind that you'll have **a $0 copay for covered Part D prescription drugs on Tier 1 when you use in-network pharmacies.**

- Be aware that the drug list has levels called “tiers.” So it’s good to know what tier your drugs are on and that drugs in each tier may have different costs.
- Know that if you have a deductible to meet first, the amount you pay generally only applies to drugs on Tiers 3, 4 and 5.

- **Learn more about coverage for the services you use regularly, including any benefit amounts (allowances) your plan offers.**

  Examples include:

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

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 **1-833-859-6031 (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.

Better health is a team effort

With an Aetna® Medicare Dual Eligible Special Needs Plan, or D-SNP, you'll have a personal care team in your corner, ready to help you feel your best.

Your care team is here to provide all-around support.

Count on them to:

- Work with you and your providers to meet your individual needs, and coordinate your health care and services
- Help you schedule provider appointments and arrange transportation
- Link you to community programs and answer questions about social services or getting Medicaid benefits

Original Medicare plus so much more

Our Dual Eligible Special Needs Plan (D-SNP) covers everything Original Medicare does, plus other benefits, programs and services. These may include a fitness membership and vision, dental and hearing benefits. Call us or see the Summary of Benefits to find out more.

About our plan

Medicare Advantage D-SNP

You might qualify for our plan if:

You live in the plan's service area

You're eligible for Medicare Part A and Part B

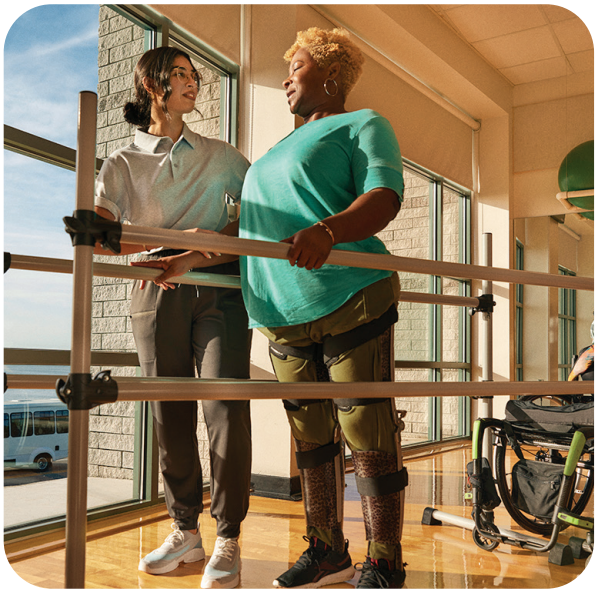
You get help with Medicare costs through the Medicare Savings Program

You qualify for state Medicaid benefits

Learn more about D-SNP plans:

Our D-SNP plans are for people who are on Medicare and also eligible for Medicaid. It replaces your Original Medicare coverage. You'll still have Medicare, but you'll get it through us, instead of the federal government.

We cover everything Original Medicare does, and offer other benefits, programs and services, too.



For more info on what this plan offers, see the Summary of Benefits.

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GOOD TO KNOW

5 reasons to have a primary care provider

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

2026-18.45.302.1

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 Extra Help.

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

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

Initial Enrollment Period

This includes the three months before, the month of and the three months after your 65th birthday.

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
- Move to a new service area
- Qualify for or lose full Medicaid eligibility
- 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.

Are your prescription drugs covered?

A formulary is a list of drugs your plan covers. Our formularies include many of the most commonly prescribed generic and brand-name drugs.

Find the drugs you need on your plan's formulary

Visit **AetnaMedicare.com/formulary** to find it, or ask your sales agent to help you.

Search for a network pharmacy near you

Visit **AetnaMedicare.com/findpharmacy** to find one.

Get your medicine delivered

If you sign up with the CVS Caremark® Mail Service Pharmacy, there's no extra cost for standard shipping.

Our pharmacists check all orders for accuracy, then mail your medicine quickly and securely to you.

Know more about Part D drugs

We understand that the cost of prescription drugs can be challenging.

If you qualify for Extra Help, you'll be eligible to receive covered Part D prescription drugs for a $0 copay at in-network pharmacies.

Plus, you can get up to a 3-month supply of eligible Part D prescription drugs.

2026-18.03.560.1-SNP

Understanding Extra Help with your prescription drugs

Extra Help is a federal program that helps cover some to all of your out-of-pocket costs for your Part D prescription drug plan. Sometimes, it's called Low-Income Subsidy, or LIS.

If you're enrolled in both Medicare and Medicaid, receive Supplemental Security Income (SSI) or qualify for a Medicare Savings Program (MSP) — you may be eligible for Extra Help.

You can apply for Extra Help online

If you don't already get Extra Help, here's how you can apply. Go to **BenefitsCheckup.org/aetna** to submit your Extra Help application.

You can also find out if you're eligible for other benefits that can help with your health care and prescription costs.

To learn more about Extra Help, go to the **Summary of Benefits**. Or contact us or a licensed sales agent to help you apply.

Aetna Medicare Full Dual Care (HMO D-SNP)
H3192 - 007

This is my plan.

2026 Summary of Benefits

We're here to help

You may have questions as you read through this information. And that's OK — we're here to help.

Not a member yet?
Call 1-833-859-6031 (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

Already a member?
Call 1-866-409-1221 (TTY: 711)8 AM to 8 PM, 7 days a week
An Aetna team member will answer your call.

Keep in mind

This is a summary of the services we cover from January 1, 2026 through December 31, 2026.

Need a complete list of what we cover and any limitations? Just visit AetnaMedicare.com/H3192-007 where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

2026-H3192.007.1

Are you eligible to enroll?

To join Aetna Medicare Full Dual Care (HMO D-SNP), you must:

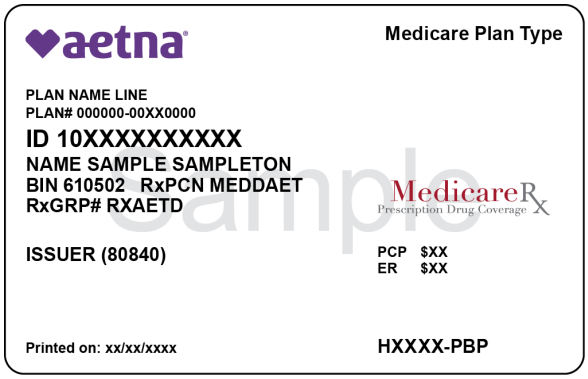
- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:
  Michigan: Allegan, Antrim, Arenac, Bay, Benzie, Charlevoix, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Jackson, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Mason, Mecosta, Missaukee, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw, Wexford
- Be in a "Medicare Savings Program" (MSP) or qualify for State Medicaid benefits. See the table below for eligibility categories.

Better health is a team effort
With our Medicare Advantage Dual Eligible Special Needs Plan, or D-SNP, you'll have a care team in your corner, ready to help you reach your best health and make life easier.

- Your **nurse care manager** is a single point of contact to help coordinate your care.
- Your **social worker** will link you to programs in your community and help with questions you have about social services.
- Your **care coordinator** will help schedule provider appointments, arrange rides, and work with you to meet your personal needs.
- We have teamed up with BeneLynk to assist you with your state Medicaid benefits and Extra Help for prescription drug assistance.

Eligibility category	What it covers
Qualified Medicare Beneficiary (QMB)	Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
Qualified Medicare Beneficiary Plus (QMB Plus)	Helps pay Medicare Part A and B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). You are also eligible for full Medicaid benefits from your state Medicaid program.
Specified Low-Income Medicare Beneficiary Plus (SLMB Plus)	Helps pay Medicare Part B premiums and possibly Part A. Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.
Full Benefit Dual Eligible (FBDE)	Medicaid may cover some of your Medicare cost sharing for medical services, depending on your state's Medicaid program. You are eligible for full Medicaid.

Be sure to show your Aetna® member ID card **AND** your state Medicaid ID card when you visit the provider or pharmacy.



What you should know

- **Plan type:** Aetna Medicare Full Dual Care (HMO D-SNP) is a D-SNP plan. This is a Medicare Advantage plan that covers prescription drugs.
- **D-SNP information:** Our D-SNP is for people on Medicare who are also eligible for some level of Medicaid assistance. It replaces your Original Medicare coverage. You'll still have Medicare, but you'll get it through us, instead of the federal government. We cover everything that Original Medicare covers and we provide additional benefits and services too.
- **Primary Care Provider (PCP):** A PCP is important to help coordinate your care. We require you to select a PCP. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Full Dual Care (HMO D-SNP) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your provider in order to see you.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit **AetnaMedicare.com/H3192-007**. For coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at **medicare.gov/medicare-and-you**, or get a copy by calling 1-800-MEDICARE (**1-800-633-4227**) (**TTY: 1-877-486-2048**), 24 hours a day, 7 days a week.

Plan premium, deductible, and maximum out-of-pocket (MOOP)

Out-of-pocket costs	
Monthly plan premium	$0
Plan deductible	$0
MOOP	$9,250 So long as Medicaid continues to pay your Medicare deductible, coinsurance, and copayments, you will not have a maximum out-of-pocket responsibility.

Medical and hospital benefits

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a **$0 copayment amount**.

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)	$0 copay
Outpatient hospital observation services	$0 copay
Outpatient hospital	$0 copay
Ambulatory surgical center	$0 copay

Primary Care Provider (PCP) and specialist visits

Benefit	Your costs in our plan
PCP	$0 copay
Specialist	$0 copay

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.
Emergency and urgent care (inside the U.S.)	$0 copay for emergency care $0 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	$0 copay for emergency care $0 copay for urgent care $0 copay for ambulance Maximum coverage: $250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency ambulance)

Diagnostic services, labs, imaging

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

Benefit	Your costs in our plan
Diagnostic tests and procedures	$0 copay
Lab services	$0 copay
Diagnostic radiology services, such as CT/CAT scan and MRI	$0 copay
Outpatient x-rays	$0 copay

Hearing services

Benefit	Your costs in our plan
Diagnostic hearing exam	$0 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 $1,250 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 a NationsHearing network provider.

Dental services

Benefit	Your costs in our plan
Dental services (non-Medicare covered)	$0 copay for covered services You get an annual benefit amount (allowance) of $2,500 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, x-rays, cleanings, fillings, extractions, and more. This benefit uses the Aetna Dental PPO Network, which is different from your medical network, for covered services. If you choose a provider outside of the Aetna Dental PPO Network, services will not be covered. 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 EyeMed provider
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $250 for covered prescription eyewear. You can only use this benefit amount at an EyeMed provider. Your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll need to pay the difference.

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	$0 copay Our plan covers up to 190 days per benefit period.
Outpatient mental health therapy	$0 copay for individual sessions $0 copay for group sessions
Outpatient psychiatric therapy	$0 copay for individual sessions $0 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. 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 copay Our plan covers up to 100 days per benefit period.
Physical and speech therapy	$0 copay
Occupational therapy	$0 copay

Ambulance and routine transportation

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

Benefit	Your costs in our plan
Ambulance (ground or air, one-way trip)	$0 copay
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 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	$0 copay
Part B Insulin	$0 copay
Other Part B drugs	$0 copay

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

Formulary Name

B2 (You can use this when referencing our list of covered drugs.)

If you qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:

Deductible

$0

Initial coverage phase

Low Income Subsidy (LIS) cost sharing during the Initial coverage phase (copayments or coinsurance may vary depending on your level of "Extra Help"):

Covered generic drugs (including brand drugs treated as generic): $0, $1.60, or $5.10.
For all other covered drugs: $0, $4.90, or $12.65.

If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:

Deductible phase

You'll pay the plan's negotiated drug cost up to the deductible limit of $615. 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:

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

Long-term Supply

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

	Standard Retail	Standard Mail
	100-day	**100-day**
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	22%	22%
Tier 4: Non-Preferred Drug	25%	25%
Tier 5: Specialty	A long-term supply is not available for drugs on Tier 5.	

You can get a 30, 60, or 100-day supply of most of your drugs through network retail and mail-order pharmacies. This includes home infusion drugs obtained through your Part D benefit. Note: Specialty drugs have a 30-day limit.

Out-of-pocket threshold

$2,100 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

Important message about what you pay for 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.

Important message about what you pay for Part D 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 insulins and vaccines.

Other covered benefits

Aetna Medicare Extra Benefits Card

You get an **Aetna Medicare Extra Benefits Card** to help pay for certain everyday expenses.

Benefit	
Over-the-Counter (OTC) Wallet	You get a $200 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 participating locations including CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®. **Important:** • If you received an Extra Benefits Card in 2025 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2026 plan year. • If you are a new member or were not enrolled in a plan with an Extra Benefits Card in 2025, you should get a new card before your plan begins. • If you 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	$0 copay for Medicare-covered acupuncture visits Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.
Chiropractic services	$0 copay for Medicare-covered chiropractic visits $0 copay for non-Medicare covered chiropractic visits Medicare coverage is limited to fixing a subluxation. For non-Medicare covered services, we also cover up to twelve visits every year. Your provider must determine medical necessity for non-Medicare covered services. We have teamed up with American Specialty Health® (ASH) to provide your chiropractic coverage.

Diabetic supplies

We exclusively cover **Accu-Chek/Roche and TRUE/Trividia** blood glucose meters and test strips as our preferred diabetic supplies.

Benefit	Your costs in our plan
Diabetic supplies	$0 copay

Fitness benefit

Benefit	Your costs in our plan
Annual physical fitness membership	$0 copay You get a basic membership to any SilverSneakers® participating fitness facility. If you prefer to exercise at home, you may order one at-home fitness kit per year through SilverSneakers. If you do not reside near a participating facility, online fitness classes are available at no additional cost to you.

Foot care (podiatry services)

Benefit	Your costs in our plan
Foot exams and treatment	$0 copay for Medicare-covered and non-Medicare covered podiatry visits For non-Medicare covered services, we cover up to six visits every year.

Home care and support

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

Benefit	Your costs in our plan
Home health care	$0 copay
Meal benefit (post-discharge)	$0 copay for meals 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 NationsMarket™ to provide this benefit.
Personal emergency response system	$0 copay Our plan covers a medical alert response system from LifeStation to provide you with 24/7 access to help in the event of a fall or an emergency.

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, oxygen equipment, and continuous glucose monitors (CGMs)	$0 copay
Prosthetics, such as braces and artificial limbs	$0 copay
Fall prevention	You will receive a $150 annual benefit amount (allowance) to purchase certain approved home and bathroom safety products.

Resources For Living®

Benefit	
Resources For Living	Resources For Living helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities, and more.

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	$0 copay

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 copay

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 the 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 qualifying, the $200 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 participating locations including CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®.

Important: If you qualify, this wallet will be added to your current Extra Benefits Card.

Aetna High Value Provider Incentive Program (HVPIP)

Eligibility requirements:
A High Value primary care provider (PCP) can offer a holistic approach to managing your care. You may be eligible for the additional supplemental benefit(s) shown below if you are diagnosed with one or more chronic conditions listed in the EOC and select a qualifying High Value PCP. For more information on the program and how to qualify, see the EOC.

Benefits:

If you qualify, you get:

- **Extra Supports Wallet bonus:**
  - $30 monthly additional benefit amount (allowance) added to your Extra Supports Wallet

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include but are not limited to: hypertension, hyperlipidemia, diabetes, cardiovascular disorders, and chronic lung disorders. Eligibility is determined by whether you have a chronic condition associated with the benefit(s). 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.

Summary of Medicaid Benefits

Here's a quick look at what's covered by Aetna Medicare Full Dual Care (HMO D-SNP) and your state Medicaid program.

Below is a summary of your Medicaid and Aetna Medicare Full Dual Care (HMO D-SNP) benefits. If you qualify for Medicare and Medicaid (or "Medical Assistance"), you're "dual eligible." This means you're eligible for benefits under both the federal Medicare program **and** the Michigan Medicaid program.

What you pay for covered services may depend on your level of Medicaid eligibility. If you meet the state's requirements for **full** Medicaid coverage, you may also receive Medicaid services not covered by Medicare. If you have questions about your Medicaid eligibility and what benefits you're entitled to, or for a full list of your covered Medicaid benefits, just call your Michigan Medicaid.

The table below gives you a summary of the benefits Medicaid covers. Aetna Medicare Full Dual Care (HMO D-SNP) covers the benefits we described earlier in the Medical and hospital benefits section. For each benefit listed below, you can see what Medicaid covers and what our plan covers. **Keep in mind:** Medicaid may cover additional benefits that are not listed below. There may be limits for some services. If you need a service that is only covered by Medicaid, the provider you pick needs to be enrolled with Medicaid.

Service	State Medicaid	Aetna Medicare Full Dual Care (HMO D-SNP)
Ambulance	✓	✓
Ambulatory surgical center (ASC) services	✓	✓
Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Policy	✓	Not Covered
Dental services	✓	✓
Diagnostic services/labs/imaging (includes diagnostic tests and procedures, labs, diagnostic radiology, and x-rays)	✓	✓
Doctor visits (primary care providers & specialists)	✓	✓
Emergency care	✓	✓
Hearing services	✓	✓
Home health care	✓	✓
Hospice	✓	Limited (see EOC for coverage details)
Inpatient hospital services	✓	✓

Service	State Medicaid	Aetna Medicare Full Dual Care (HMO D-SNP)
Intermediate care facility – intellectual disabilities (ICFI-MR)	✓	Not Covered
Long-term acute hospital services (LTACH)	✓	Not Covered
Long-term nursing home care (i.e., custodial nursing home care)	✓	Not Covered
Maternal and infant health program (MIHP) services	✓	Not Covered
Mental health services	✓	✓
Occupational therapy	✓	✓
Out-of-state services authorized by the contractor	✓	Not Covered
Outpatient hospital services	✓	✓
Personal care services	✓	Not Covered
Physical and speech therapy	✓	✓
Prescription drugs	✓	✓
Preventive care	✓	✓
Skilled nursing facility (SNF)	✓	✓
Targeted care management (pregnant women or under 21)	✓	Not Covered
Transportation	✓	Not Covered
Urgently needed services	✓	✓
Vision services	✓	✓
Well child/EPSDT for persons under age 21	✓	Not Covered

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Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-833-859-6031 (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 **1-833-859-6031 (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, 2027.
- ☐ **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.

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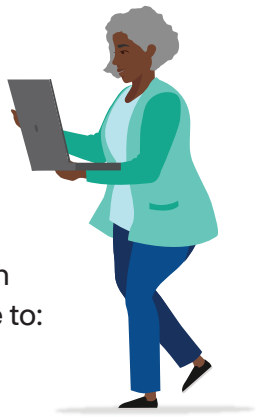
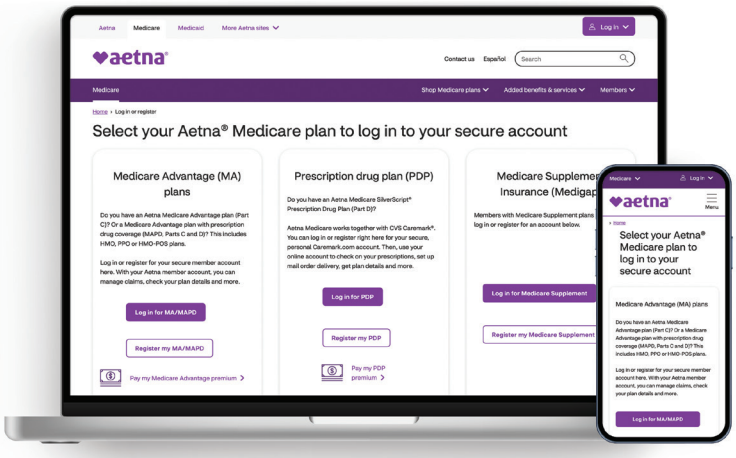
Manage your plan online



Your secure member website and Aetna Health℠ 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 **aet.na/EGMemberLogin** and use your member ID card to sign up for your secure member website.

Manage your plan anytime, on the go

Just visit **aet.na/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.

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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.

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Aetna Medicare - H3192

For 2025, Aetna Medicare - H3192 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
Drug Services Rating:	★★★½☆

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.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at 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 866-409-1221 (toll-free) or 711 (TTY).

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.

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Sign up for your plan

3 ways to enroll:

By phone

Call us or a licensed sales agent to enroll over the phone or set up a meeting. You can reach us at **1-833-859-6031 (TTY: 711)**.

From October 1–March 31, we're here 8 AM–8 PM, 7 days a week. From April 1–September 30, we're here 8 AM–8 PM, Monday–Friday.

By fax

Complete and fax the enrollment form in the back of this guide to **1-844-984-0393**.

By mail

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

Start your enrollment off right

When completing your enrollment form, don't forget to:

☐ Tell us who your primary care provider (PCP) is

- Most of our plans require that you choose a PCP. **Be sure to write your PCP's info on your enrollment form.** This helps us better support your care and promotes a smooth enrollment process. Your PCP will be listed on your member ID card.
- If your plan requires a PCP and you don't list one on your enrollment form, we'll assign one to you. You can change your PCP at any time on your secure member website. Or call us at the number on your member ID card for help.
- Visit **AetnaMedicare.com/findprovider** to view in-network providers.

☐ Sign and date it

Let's work together to complete your enrollment — be sure to sign and date your form. This will help avoid any delays.

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What happens next?

You'll hear from us within about a week 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.

Welcome call

You may receive a call verifying your plan choice. We'll also make sure your providers and medicines are covered in our network.

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

Use this card, and your Medicaid card if you have one, each time you visit a provider, hospital or pharmacy. This is different from the Medicare card you receive from the federal government.

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

Welcome kit

This kit includes tips, tools and resources to help you get the most out of your plan.

You'll get your welcome kit in the mail.

Health survey

A member of your care team will call you within 90 days to complete your health survey. This is important because it helps them design a personalized care plan just for you. Your plan will help you take advantage of Aetna® health and wellness benefits and services.

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 2025.

Visit AetnaMedicare.com/mydsnp to find your EOC online.

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 at least 48 hours 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:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
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.	

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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.

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Aetna Medicare
2026 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: **1-833-859-6031 (TTY: 711)**	**Through your agent**: Give them the completed form	**Fax** to: Attention: Enrollment Department Fax: **1-844-984-0393**	**Mail** to: Aetna Medicare PO Box 14066, Lexington, KY 40512

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 **1-833-859-6031 (TTY: 711)**. We're here 8 AM to 8 PM, seven 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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Confirm your enrollment period

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 10/15/25 and 12/7/25** 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 1/1/26 and 3/31/26:

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

Between 4/1/26 and 12/31/26:

☐ 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 **1-833-859-6031 (TTY: 711)**. We're here 8 AM to 8 PM, seven 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 Full Dual Care (HMO D-SNP) (H3192-007) **$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 Signature (HMO)"*). 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 **1-833-859-6031 (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	Sex	Phone number
__ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	☐ Male ☐ Female	(_ _ _) _ _ _ - _ _ _ _ Is this a mobile number? ☐ Yes ☐ No

Email address

Enter your permanent 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 street address

City	County	State	ZIP code

Mailing address - including Apt/Suite/Unit (if different from your permanent street address)

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.

	Effective Date:
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _	**HOSPITAL (Part A)** _ _/_ _/_ _ _ _
	MEDICAL (Part B) _ _/_ _/_ _ _ _

Answer these important questions

☐ Yes ☐ No

1. **Will you have other prescription 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 Medicaid program?**

   If "Yes," write in your Medicaid 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"):

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 **1-833-859-6031 (TTY: 711)** if you need information in an accessible format other than what's listed above. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

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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 <u>not</u> 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 D-SNPs 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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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 14066, Lexington, KY 40512
Fax: 1-844-984-0393

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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, seven 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.

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

The Aetna Medicare pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Rural Kansas, Urban Kansas, Rural Michigan, Urban Missouri, 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 **1-833-859-6031 (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.

Note: If you obtain covered services from an out-of-network physician or provider who does not accept Medicare assignment, you will be responsible for the cost sharing shown above, plus any difference between the amount we pay the provider and the Medicare limiting charge. If you obtain durable medical equipment from an out-of-network supplier who does not accept Medicare assignment, the plan will pay based on the billed amount and you will be responsible for the cost sharing shown above.

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

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.

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

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 but are not limited to: dementia, chronic heart failure, chronic lung disorders, chronic kidney disease, and chronic alcohol use disorder and other substance use disorders (SUDS). Eligibility is determined by whether you have a chronic condition associated with the benefit(s). 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.

2026-18.28.315.1-SNP

Due to legislation in Arkansas, effective January 1, 2026, you will not be able to utilize the following services within the state of Arkansas: CVS Retail, CVS Caremark Mail Service Pharmacy, CVS Specialty, and Omnicare 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 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 ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe 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)

လာကမၤန့ၣ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိာ်လာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီဉ်ဂံၢ် လၢအအိဉ်ဖဲလာ်တီလာ်မီအံၤအဖီခိဉ်နၣ်တက့ၢ်. (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)

Y0001_Y0130_H6399_2025_V3


Here’s to your
best health!

aetna®

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 Health℠ 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.

2026-18.39.603.1 (8/25)