Summary of Benefits 2027

January 1, 2027 through December 31, 2027
This is a summary of your plan's costs and coverage. For a complete list of what we cover and any limitations, review the plan's *Evidence of Coverage* (EOC) at AetnaMedicare.com/H5521-461 or call us to request a copy.

Your questions are important to us, and we're here to help

If you are an Aetna plan member, call:
1-844-826-5291 (**TTY:** 711)
8 AM to 8 PM, 7 days a week

If you are not yet an Aetna plan member, call:
1-833-217-9081 (**TTY:** 711)
October 1–March 31: 8 AM to 8 PM, 7 days a week
April 1–September 30: 8 AM to 8 PM, Monday–Friday

An Aetna team member will answer your call.

2027-H5521.461.1

About this plan

Aetna Medicare Longevity (PPO I-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. It is designed for people who live in an institution and/or live in the community but who need a level of care that is usually provided in a nursing home. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care. Please take a moment to review the following important information:

- **Primary care provider (PCP):** We require that you select a network PCP to help coordinate your care. When you enroll, we'll ask which PCP you have chosen. If you don't choose a PCP, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Longevity (PPO I-SNP) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your PCP in order to see you.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit **AetnaMedicare.com/H5521-461**. 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.

Are you eligible to enroll?

To join **Aetna Medicare Longevity (PPO I-SNP)**, you'll need to meet the following criteria:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Reside in or expect to reside in one of our participating nursing facilities for greater than 90 days
- Live in the plan's service area, which includes the following counties:
  New York: Albany, Allegany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, Yates

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

Understanding out-of-pocket costs

- **Plan premium:** the amount you pay monthly to keep your health insurance active.
- **Deductible:** the amount you must pay for health care before our plan pays.
- **Maximum out-of-pocket:** the most you'll pay out of pocket in a plan year for covered care.

Out-of-pocket costs	
Monthly plan premium	$10.70 You must continue to pay your Medicare Part B premium.
Plan deductible	$0

Out-of-pocket costs	
MOOP	$9,850 for in-network services $14,800 for in- and out-of-network services combined This is the most you pay for copays, coinsurance, and other costs for medical services for the year. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP.

Medical and hospital benefits

Hospital coverage

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

Benefit	Your in-network costs	Your out-of-network costs
Inpatient	$2,050 per stay The plan covers 90 days each benefit period and up to 60 lifetime reserve days. Lifetime reserve days can only be used once.	30% per stay
Outpatient hospital observation services	20% coinsurance	30% coinsurance
Outpatient hospital	20% coinsurance	30% coinsurance
Ambulatory surgical center	20% coinsurance	30% coinsurance

Primary care provider (PCP) and specialist services

Benefit	Your in-network costs	Your out-of-network costs
PCP	$0 copay	30% coinsurance
Specialist	20% coinsurance	30% coinsurance

Preventive, emergency, and urgent care

Benefit	Your in-network costs	Your out-of-network costs
Preventive care	$0 copay	0% - 30% coinsurance 0% coinsurance for the pneumonia, flu/influenza, hepatitis B, and COVID-19 vaccines 30% coinsurance for all other Medicare-covered preventive services

Benefit	Your in-network costs	Your out-of-network costs
	For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.	
Emergency and urgent care (inside the U.S.)	$115 copay for emergency care $40 copay for urgent care	$115 copay for emergency care $40 copay for urgent care

Diagnostic services, labs, and imaging

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

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic tests and procedures	20% coinsurance 0% coinsurance for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing	30% coinsurance
Lab services	$0 copay	30% coinsurance
Diagnostic radiology services, such as CT/ CAT scan and MRI	20% coinsurance	30% coinsurance
Outpatient x-rays	20% coinsurance	30% coinsurance

Hearing services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic hearing exam	20% coinsurance	30% coinsurance
Routine hearing exam	$0 copay You get one routine hearing exam every year. You can visit a provider in the NationsHearing® network or an out-of-network provider.	30% coinsurance
Hearing aids	You get an annual benefit amount (allowance) of $750 per ear. If the cost is over the benefit amount, you pay the difference. When you use our authorized vendor, NationsHearing®, your benefit amount will be applied at the time of purchase. If you use an unauthorized vendor, you will have to pay upfront and request reimbursement from NationsHearing.	If you do not use our authorized vendor, NationsHearing, for this benefit, you will have to pay out of pocket at the time of purchase and request reimbursement. You will not be reimbursed for the full amount and will be responsible for any costs over the allowable amount. Out-of-network claims are reimbursed at a lower rate up to the applicable allowable amount.

Dental services

Benefit	Your in-network costs	Your out-of-network costs
Dental services (non-Medicare covered)	$0 copay for covered services You get an annual benefit amount (allowance) of $1,500 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, x-rays, cleanings, fillings, extractions, and more. You can use a provider in or out of the Aetna Dental PPO Network, which is different from your medical network, for covered services. However, if you use a provider outside of the network, you may be required to pay in full for services and submit a request for reimbursement. See EOC for details on exclusions and limitations.	$0 copay for covered services

Vision services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic eye exam (includes diabetic eye exams)	0% - 20% coinsurance 0% coinsurance for diabetic eye exams 20% coinsurance for all other Medicare-covered eye exams	30% coinsurance
Glaucoma screening	$0 copay	30% coinsurance
Routine eye exam (one exam every year)	$0 copay with an EyeMed network provider	The out-of-network routine eye exam is covered up to $50. You may be required to pay up front and submit a reimbursement request to EyeMed. You will be responsible for any billed amount over $50.
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $250 for covered prescription eyewear. We have teamed up with EyeMed to provide this benefit. When you use an EyeMed network provider, your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll need to pay the difference. If you use a provider outside of the EyeMed network, you may be required to pay up front and request reimbursement up to your benefit amount. You may also be responsible for additional costs. See EOC for details.	

Mental health services

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

Benefit	Your in-network costs	Your out-of-network costs
Inpatient psychiatric hospital stay	$2,050 per stay There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.	30% per stay
Outpatient mental health therapy	20% coinsurance for individual sessions 20% coinsurance for group sessions	30% coinsurance for individual sessions 30% coinsurance for group sessions
Outpatient psychiatric therapy	20% coinsurance for individual sessions 20% coinsurance for group sessions	30% coinsurance for individual sessions 30% coinsurance for group sessions

Skilled nursing facility (SNF) and therapy

Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

Benefit	Your in-network costs	Your out-of-network costs
SNF care	$0 per day, days 1-100 Our plan covers up to 100 days per benefit period.	30% per stay
Physical and speech therapy	$0 copay	30% coinsurance
Occupational therapy	$0 copay	30% coinsurance

Ambulance and routine transportation

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

Benefit	Your in-network costs	Your out-of-network costs
Ambulance (ground or air, one-way trip)	20% coinsurance	20% coinsurance
Routine, non-emergency transportation	Not Covered	Not Covered

Medicare Part B drugs

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

Benefit	Your in-network costs	Your out-of-network costs
Chemotherapy drugs	20% coinsurance	30% coinsurance

Benefit	Your in-network costs	Your out-of-network costs
Part B Insulin	$35 copay	$35 copay
Other Part B drugs	20% coinsurance	30% coinsurance

Medicare Part D drugs

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

Prescription drug costs

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

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

Deductible phase	You'll pay the plan's negotiated drug cost up to the deductible limit of $700.
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
Generic and brand name drugs	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
Generic and brand name drugs	25%	25%

Out-of-pocket threshold	$2,400 is the maximum amount you will pay for your yearly Part D out-of-pocket costs.
Catastrophic coverage phase	In this phase, the plan pays the full cost for your covered Part D drugs. You'll pay $0 for generic and brand name drugs in this phase.

Insulins and vaccines	Part D insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, even if you haven't paid your deductible. Part D preventive vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible. Check your formulary guide for a list of covered Part D insulins and vaccines.

Other covered benefits

Alternative medicine

Benefit	Your in-network costs	Your out-of-network costs
Acupuncture	20% coinsurance for Medicare-covered acupuncture visits	30% coinsurance 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	20% coinsurance for Medicare-covered chiropractic visits	30% coinsurance for Medicare-covered chiropractic visits
	Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.	

Diabetic supplies

Benefit	Your in-network costs	Your out-of-network costs
Diabetic supplies	20% coinsurance for Medicare-covered diabetic supplies 20% coinsurance for Medicare-covered continuous glucose monitors (CGMs)	20% coinsurance for Medicare-covered diabetic supplies 30% coinsurance for Medicare-covered continuous glucose monitors (CGMs)

Foot care (podiatry services)

Benefit	Your in-network costs	Your out-of-network costs
Foot exams and treatment	20% coinsurance for Medicare-covered podiatry visits $0 copay for non-Medicare covered podiatry visits	30% coinsurance for Medicare-covered podiatry visits 30% coinsurance for non-Medicare 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 in-network costs	Your out-of-network costs
Home health care, such as part-time skilled nursing and health aide services, and physical therapy	$0 copay for Medicare-covered home health care services Non-Medicare covered home health care services are not covered.	30% coinsurance for Medicare-covered home health care services

Medical equipment and supplies

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

Benefit	Your in-network costs	Your out-of-network costs
Durable medical equipment (DME), such as wheelchairs, crutches, and oxygen equipment	20% coinsurance	30% coinsurance
Prosthetics, such as braces and artificial limbs	20% coinsurance	30% coinsurance

Music therapy

Benefit	Your in-network costs	Your out-of-network costs
Music therapy	$0 copay We cover up to 25 small group music listening sessions per year. Sessions are offered at the facility in which you reside with a certified curriculum. Your Aetna Longevity care team will support your access to this benefit.	$0 copay

Over-the-counter (OTC) benefit

The OTC benefit provides select health and wellness products.

Benefit	
OTC benefit amount (allowance)	$150 quarterly benefit amount (allowance)

Benefit	
	You will receive a quarterly benefit amount (allowance) to help pay for certain OTC health and wellness products like first aid supplies, external pain relievers, adult care products, and more. • The benefit amount is available the first day of each calendar quarter. Any unused amount will not roll over into the next quarter. • The benefit amount is not connected to a payment or debit card. • You can get OTC products through your care support team. You can also use the CVS Flex Benefits™ app, go online at **CVS.com/Aetna**, or shop by phone. • View the OTC catalog for a full product listing and details on how the benefit works at **AetnaMedicare.com/H5521-461**.

Substance use disorder services

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

Benefit	Your in-network costs	Your out-of-network costs
Outpatient substance use disorder services	20% coinsurance for individual sessions 20% coinsurance for group sessions	30% coinsurance for individual sessions 30% coinsurance for group sessions

Special supplemental benefits

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

Companion Care	
Eligibility requirements	If you are diagnosed with one or more of the chronic conditions listed in the EOC and meet eligibility criteria, you may be eligible for this benefit under our plan. Enrollment in the plan does not guarantee eligibility. You cannot self-attest to a diagnosis for the chronic conditions listed in the EOC. You will be notified if you are determined to be eligible for this program.
Benefits	The Companion Care benefit is offered through our authorized vendor, The Helper Bees®. For members who qualify, The Helper Bees will provide a credentialed companion that supports members by helping them engage in activities that foster social connection and relationship building. Eligible members receive up to 50 hours of Companion Care services from The Helper Bees every 3 months. Companion Care services begin on the first day of each calendar quarter.

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) and you meet all other criteria. Even if you have a listed chronic condition, you may not necessarily receive the benefit because other eligibility and coverage criteria may apply. Standards and conditions vary for each benefit. Contact us to confirm the specific SSBCI condition requirements for the benefit(s) for this plan and determine your eligibility.

Disclaimers

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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

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

Aetna is part of the CVS Health® family of companies.

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

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 **1-844-826-5291** (**TTY:** 711) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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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 1-833-217-9081 (**TTY:** 711). From October 1 to March 31, you can call us 7 days a week from 8 AM to 8 PM local time. From April 1 to September 30, we're here Monday through Friday from 8 AM to 8 PM local time.

Understanding the benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit AetnaMedicare.com or call 1-833-217-9081 (**TTY:** 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding important rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ 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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Notice of Availability (NOA)

TTY: 711

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

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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)

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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)

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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)

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

ເພ່ ອ ້ ໍ ໃຊ ້ ການ ບ ໍ ລ ິ ການ ພ າ ສ າ ໂ ດ ຍ ບ ເ ສ ຍ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ ໃ ດ ໆ, ໃ ຫ ້ ໂ ທ ຫ າ ເ ບ ໍ ໂ ທ ໃ ນ ເ ອ ກ ະ ສ າ ນ ້ ໍ. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរស័ព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

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

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)

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

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