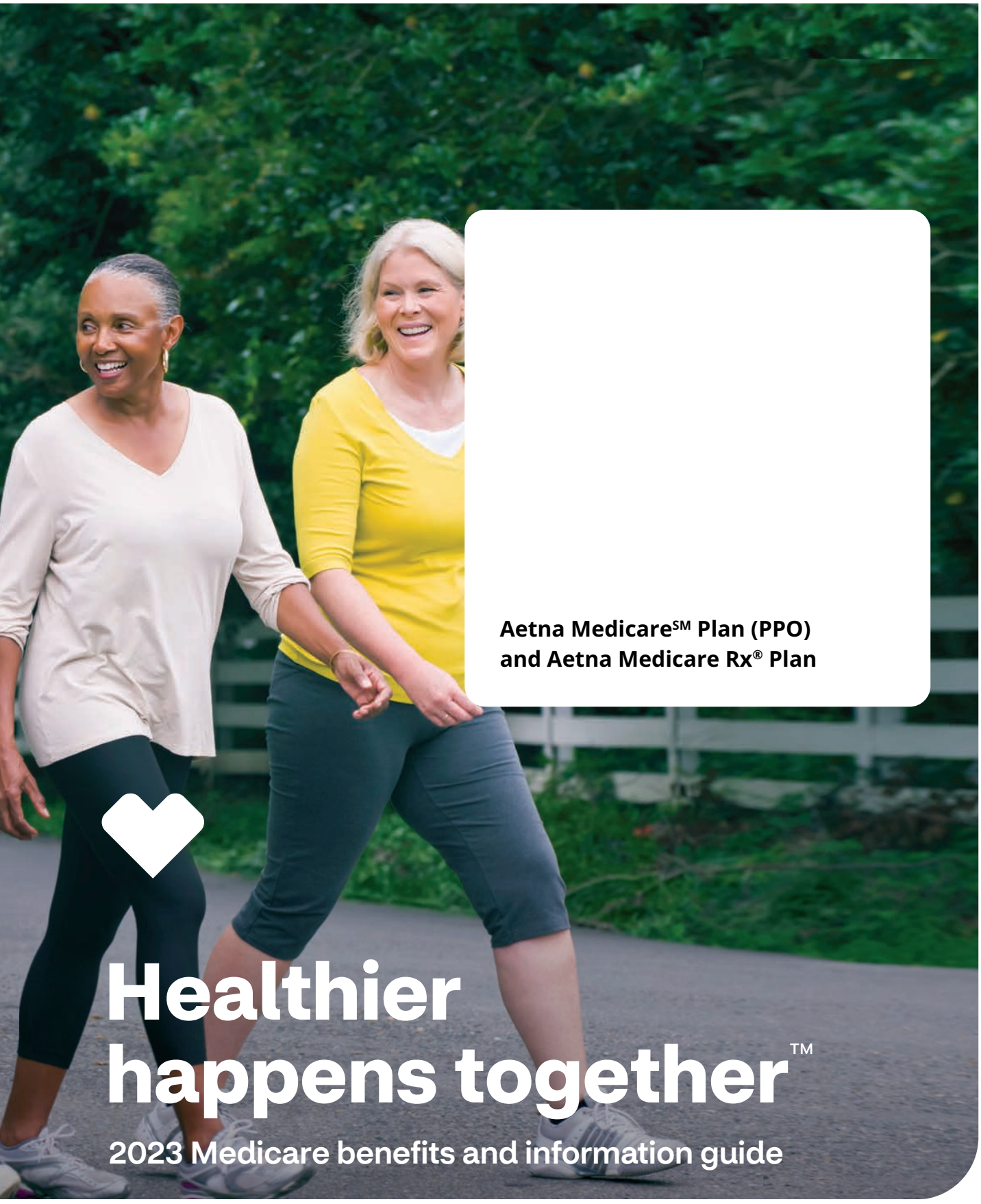


Aetna Medicare℠ Plan (PPO)
and Aetna Medicare Rx® Plan

Healthier happens together™

2023 Medicare benefits and information guide

aetna®

Y0001_GRP_4742a_2023_M

Welcome!

Aetna Medicare℠ Plan (PPO)
and Aetna Medicare Rx® Plan

Plans centered around you

As part of the CVS Health® family, we deliver a total, connected approach to your health and well-being. So you can age actively with energy and optimism.

We're here to walk you through your coverage. Just give us a call — we're here to help.

18.32.300.1-GRP-MAPD_C

Welcome to Aetna Medicare

We want you to have a rewarding health care experience. Our plans can help.

This packet contains:

- Information on the benefits, programs and services available to you
- Details to help you better understand the plan features

You'll be automatically enrolled

You don't have to take any action to join the plan. You will be automatically transferred into the Aetna Medicare PPO Plan on January 1, 2023 unless you complete and submit the Open Enrollment Change Form electing a new plan or make a change by November 10th, 2022. The County of San Mateo Open Enrollment Form is available online at smcgov.org/hr/OE-1 .

If you wish to have a paper form mailed to you, please call the County of San Mateo – Benefits Division at **(650)363-1919** or email **benefits@smcgov.org , Monday–Thursday 7:00am-6:00pm PST.**

Questions?

Just call us at **1-800-307-4830 (TTY: 711)**.
We're here 8 AM to 9 PM ET, Monday through Friday.

Y0001_GRP_3249b_2021_C

Table of contents

72.00.3691-GRP B

TIP

About IRMAA

You'll get a Medicare Income-Related Monthly Adjustment Amount (IRMAA) notice if you have Medicare Part B or Part D and the U.S. Social Security Administration (SSA) determines that an IRMAA applies to you. This notice includes information about the determination by Social Security and your appeal rights.

When should I get it?
It can come at anytime.

Who sends it?
Social Security will contact you if you have to pay IRMAA, based on your income. The amount you pay can change each year, and it should be paid directly to the SSA.

What should I do if I get this notice?
Keep the notice. If you disagree with the notice, you can contact SSA to appeal.

A Medicare plan for you

Let's start with what matters most.

A history of care

We've provided access to Medicare coverage for more than 50 years.

Providers you trust

Our nationwide provider coverage helps connect you with the doctors and hospitals you count on for care.

Your prescriptions

Our plans cover many commonly prescribed drugs. And you can get most of them delivered to you with the CVS Caremark® Mail Service Pharmacy.

18.02.130.1_C

Original Medicare plus so much more

Our plans offer all the benefits of Original Medicare, plus other programs and services it doesn't offer.

Healthy Home Visit

A licensed health care professional can come to your home to review your health needs and do a home safety assessment. During the visit, they may also review your medications, complete some health screening tests and recommend services that can support your health needs. If you feel more comfortable with a virtual visit, a phone or video option may also be available.

The Resources For Living® program

We can connect you to a wide range of services right in your area — from personal care, housekeeping and maintenance to caregiver relief and more.

24-Hour Nurse Line

Need a quick answer to a health question or have a concern? You can talk to one of our registered nurses anytime, day or night.* Of course, in an emergency, dial **911** or go to the closest emergency room.

Nurse care management

These programs can help you manage chronic conditions and understand complex medical issues. If you qualify, we'll assign you a nurse care manager to work with you and your doctors to support your care plan.

Virtual Care

Telehealth: Meet virtually with a primary care physician (PCP) or an urgent care center provider by phone, video or mobile app. Check with your PCP or urgent care center to see if they offer telehealth services.

Teladoc®: You can access a national network of U.S. board-certified doctors by phone, video or mobile app. Get quality health care anywhere and anytime.

MDLIVE®: Talk by video to a board-certified psychiatrist or a licensed therapist — anytime, including nights and weekends. Providers are specially trained in elder care.

Whether you choose telehealth, Teladoc or MDLIVE, you're covered for many non-emergency medical needs, such as cold and flu symptoms, allergies, skin problems and prescription refills.

*While only your doctor can diagnose, prescribe or give medical advice, our nurses can provide information on more than 5,000 topics. Contact your doctor first with any questions regarding your health care needs. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional.

Aetna® Medicare Advantage with prescription drug coverage

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

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

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

See if your prescriptions are covered

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

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

- Flip to this guide's Summary of Benefits section to view the list.
- Write down the formulary name and the plan's tier structure (for example, 3-tier, 5-tier, etc.) shown under "Pharmacy — Prescription Drug Benefits."
- Go to aetnaretireeplans.com.
- Follow the prescription drug list search instructions for plans offered through an employer or group sponsor.

Don't have access to a computer or the internet? Call us at 1-800-307-4830 (TTY : 711).

18.03.115.1-C3_C

Pharmacy coverage from coast to coast

Our pharmacy network includes national chains and local options.

Find a network pharmacy close to you

Visit aetnaretireeplans.com.

No computer or internet? No worries.

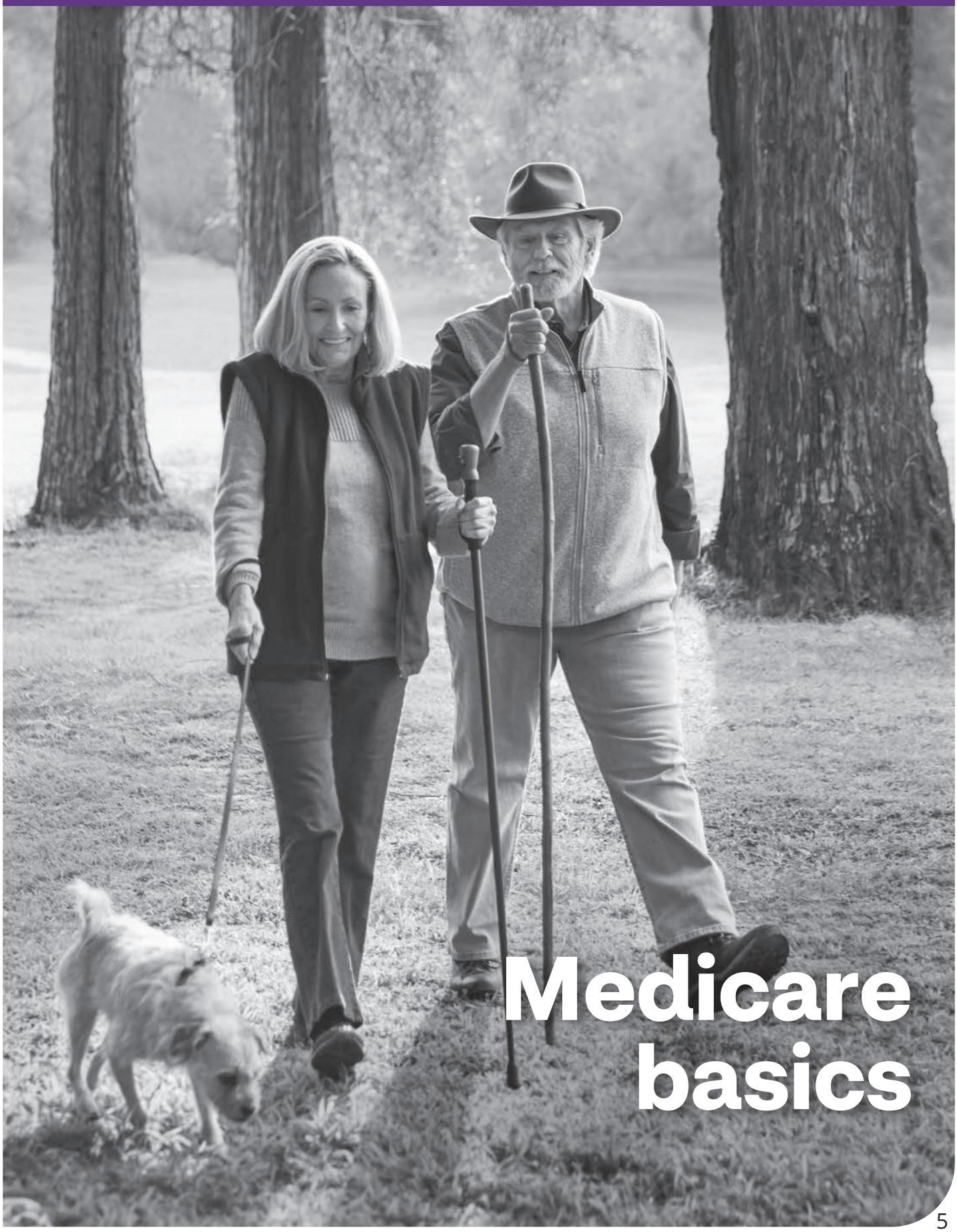
Call us at 1-800-307-4830 (TTY : 711).
We're here 8 a.m. to 9 p.m. EST Monday Through Friday.

Save a trip with home delivery

With CVS Caremark® Mail Service Pharmacy* (a preferred pharmacy), standard shipping is always free. Your medicine is securely packed, then checked for accuracy by a registered pharmacist. Finally, it's mailed quickly and safely to you.

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

*This pharmacy will be a pharmacy in our network in 2023. They may also contract with other plans.



Medicare basics

18.00.540.1_C

About your plan

Aetna Medicare℠ Plan (PPO)

A PPO is a preferred provider organization plan. You'll have the freedom and flexibility to see any licensed provider or hospital. **Your share of the cost is the same for any provider**, as long as they accept Medicare patients and your Aetna® plan.

Does your provider accept our plan? They most likely will. That's because more than **1,000,000 network doctors and specialists** and over **4,000 network hospitals** accept the Aetna Medicare Advantage plan.

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

Summary of Benefits

18.00.106.1-PPO_D

Aetna® Medicare Plan (PPO)

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

More than one plan may be available to you.

Benefits and Premiums are effective January 1, 2023 through December 31, 2023

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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

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

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

PLAN FEATURES	**Network & out-of-network providers.**
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay.	$1,500
It will apply to all medical expenses except Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.	
HOSPITAL CARE*	**This is what you pay for network & out-of-network providers.**
Inpatient Hospital Care	$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Stay	$10
Frequency:	per stay
Outpatient Services & Surgery	$10
Ambulatory Surgery Center	$10

PHYSICIAN SERVICES	This is what you pay for network & out-of-network providers.
Primary Care Physician Visits	$10
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$20

PREVENTIVE CARE	This is what you pay for network & out-of-network providers.
Medicare-covered Preventive Services	$0

• Abdominal aortic aneurysm screenings
• Alcohol misuse screenings and counseling
• Annual Well Visit - One exam every 12 months.
• Bone mass measurements
• Breast exams
• Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
• Cardiovascular behavior therapy
• Cardiovascular disease screenings
• Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
• Depression screenings
• Diabetes screenings
• HBV infection screening
• Hepatitis C screening tests
• HIV screenings
• Lung cancer screenings and counseling
• Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.
• Nutrition therapy services
• Obesity behavior therapy
• Pelvic Exams - one routine GYN visit and pap smear every 24 months.

• Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service

• Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)

• Sexually transmitted infections screenings and counseling

• Tobacco use cessation counseling

• Welcome to Medicare preventive visit

Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0
EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers.**
Emergency Care; Worldwide (waived if admitted)	$20
Urgently Needed Care; Worldwide	$10
DIAGNOSTIC PROCEDURES*	**This is what you pay for network & out-of-network providers.**
Diagnostic Radiology CT scans	$0
Diagnostic Radiology Other than CT scans	$0
Lab Services	$0
Diagnostic testing & procedures	$0
Outpatient X-rays	$0

HEARING SERVICES	This is what you pay for network & out-of-network providers.
Routine Hearing Screening We cover one every twelve months	$0
Medicare Covered Hearing Examination	$20
Hearing Aid Benefit Vendor:	N/A Not Covered
DENTAL SERVICES	**This is what you pay for network & out-of-network providers.**
Medicare Covered Dental* Non-routine care covered by Medicare.	$20
VISION SERVICES	**This is what you pay for network & out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$10
Diabetic Eye Exams	$0
Medicare Covered Eye Exam	$20
Vision Eyewear Reimbursement Applies to in or out of network	$150 once every 24 months
MENTAL HEALTH SERVICES*	**This is what you pay for network & out-of-network providers.**
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 per stay
Outpatient Mental Health Care Individual visit	$20
Partial Hospitalization	$20
Inpatient Substance Abuse The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$0 per stay
Outpatient Substance Abuse Individual visit	$20

SKILLED NURSING SERVICES*	This is what you pay for network & out-of-network providers.
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-100

Limited to 100 days per Medicare Benefit Period.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.

A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES*	This is what you pay for network & out-of-network providers.
Outpatient Rehabilitation Services (Speech, physical, and occupational therapy)	$10

AMBULANCE SERVICES	This is what you pay for network & out-of-network providers.
Ambulance Services	$50

Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.

TRANSPORTATION SERVICES	This is what you pay for network & out-of-network providers.
Transportation (non-emergency)	24 trips with 60 miles allowed per trip

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network & out-of-network providers.
Medicare Part B Prescription Drugs	$0

MEDICARE PART D PRESCRIPTION DRUGS	This is what you pay for network & out-of-network providers.

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section below for your plan benefits at each part D stage, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network & out-of-network providers.
Allergy Shots	$0
Allergy Testing	$20
Blood	$0
All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	$10
Chiropractic Services*	$15
Medicare covered benefits only.	
Diabetic Supplies*	$0
Includes supplies to monitor your blood glucose.	
Durable Medical Equipment/ Prosthetic Devices*	$0
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Medical Supplies*	$0
Medicare Covered Acupuncture	$15
Outpatient Dialysis Treatments*	$20
Podiatry Services	$20
Medicare covered benefits only.	
Pulmonary Rehabilitation Services	$10
Radiation Therapy*	$0

ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network & out-of-network providers.
Fitness Benefit	SilverSneakers
Meals	$0
Covered up to 14 meals following an inpatient stay.	
Resources For Living®	Covered
For help locating resources for every day needs.	
Teladoc™	$0
Telemedicine services with a Teladoc™ provider. State mandates may apply.	
Telehealth	Covered
Telemedicine Services. Member cost share will apply based on services rendered.	
Telehealth PCP	$10
Telehealth Specialist	$20
Telehealth Other Health care Providers	$20
Telehealth Individual Mental Health	$20
Telehealth Group Mental Health	$20
Telehealth Individual Psychiatric Services	$20
Telehealth Group Psychiatric Services	$20
Telehealth Behavioral Health	$0
Vendor: MD Live	
Telehealth Urgent care	$10
ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	**This is what you pay for network & out-of-network providers.**
Acupuncture	$15
twenty visits every year. in lieu of anesthesia and for treatment of chronic pain.	
Enhanced Chiropractic Services*	$15
Visits: twenty visits every year per year.	
Routine Physical Exams	$0
One exam per calendar year	

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

See next page for Pharmacy-Prescription Drug Benefits.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-Year deductible for Prescription drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network P1

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

Formulary (Drug List) Classic+

Initial Coverage Limit (ICL) $4,660

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

4 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	**Standard**	**Preferred Retail**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	$9	$10	$18	$18	$30
Tier 2 - Preferred Brand Preferred Brand Drugs	$20	$20	$40	$40	$60
Tier 3 - Non-Preferred Brand Non-Preferred Brand Drugs	$35	$35	$60	$60	$105
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	30%, but not more than $150	30%, but not more than $150	Limited to one-month supply	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail

pharmacy and you may receive up to a 31 day supply.

Coverage Gap

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost-sharing for covered Part D drugs after the Initial Coverage Limit and until you reach $7,400 in prescription drug expenses is indicated below.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage:	You pay $0.

Catastrophic Coverage benefits start once $7,400 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Applies

Non-Part D Supplemental Benefit

- Not Covered

Medical Disclaimers

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

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

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

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

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

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

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

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

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

Pharmacy Disclaimers

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage

beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

Aetna's pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Urban Pennsylvania, Suburban Utah, Suburban West Virginia, Suburban Wyoming. 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, please call 1-866-241-0357 (TTY: 711) or consult the online pharmacy directory at http://www.aetnaretireeplans.com.

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

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

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

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

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

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-866-241-0357, 24 hours a day, 7 days a week. TTY users call 711.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

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

plan cannot:

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

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

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

Plan Disclaimers

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

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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.

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

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

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

You can read the *Medicare & You 2023* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

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

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

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-307-4830. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-307-4830。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-307-4830。我們講中文的人員將樂意為您提供幫助。這 是一項

免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-307-4830. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-307-4830. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-307-4830 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-307-4830. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-307-4830번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-307-4830. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-307-4830. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-307-4830 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-307-4830. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-307-4830. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-307-4830. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-307-4830にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-800-307-4830. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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

Y0001_GRP_1099_3732a_2021_M

18.00.120.1-PPO_B

Star Ratings

Know how well
your plan rates

TIP

Check Medicare's Star Ratings

Star Ratings can help you learn more about the Medicare plan you're offered. They can give you insight into the parts of a health plan you care most about. Learn how to find your plan's Star Rating on the next page.

Here's how Star Ratings work

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

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

- Helping you stay 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.

How to find your plan's Star Rating

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

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

Aetna Medicare Plan (PPO)

State	Contract number
Alabama	H5521
Alaska	H5521
Arizona	H5521
Arkansas	H1608, H5521
California	H5521
Colorado	H5521
Connecticut	H5521
Delaware	H5521
District of Columbia	H5521
Florida	H5521
Georgia	H1608, H3288, H5521
Hawaii	H5521
Idaho	H5521, H9431
Illinois	H1608, H5521, H7301
Indiana	H5521
Iowa	H1608, H5521
Kansas	H1608, H5521
Kentucky	H5521
Louisiana	H5521
Maine	H5521
Maryland	H5521
Massachusetts	H5521
Michigan	H5521
Minnesota	H5521
Mississippi	H5521
Missouri	H1608, H5521

State	Contract number
Montana	H5521
Nebraska	H1608, H5521
Nevada	H5521
New Hampshire	H5521, H9431
New Jersey	H5521
New Mexico	H5521, H9431
New York	H5521
North Carolina	H5521
North Dakota	H5521
Ohio	H1608, H5521
Oklahoma	H3288, H5521
Oregon	H5521, H9431
Pennsylvania	H5521, H5522
Rhode Island	H5521, H9431
South Carolina	H5521
South Dakota	H1608, H5521
Tennessee	H5521
Texas	H3288, H5521
Utah	H5521
Vermont	H5521
Virginia	H5521
Washington	H5521
West Virginia	H1608, H5521
Wisconsin	H5521
Wyoming	H5521

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Aetna Medicare - H1608

For 2022, Aetna Medicare - H1608 received the following Star Ratings from Medicare:

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

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

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

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

The number of stars show how well a plan performs.

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

18.03.150.1_B

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

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

Y0001_GRP_2022_H1608_M

This page intentionally left blank.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Aetna Medicare - H3288

For 2022, Aetna Medicare - H3288 received the following Star Ratings from Medicare:

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

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

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

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

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

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

Y0001_GRP_2022_H3288_M

This page intentionally left blank.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Aetna Medicare - H5521

For 2022, Aetna Medicare - H5521 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY).
Current members please call 888-267-2637 (toll-free) or 711 (TTY).

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

Y0001_GRP_2022_H5521_M

This page intentionally left blank.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Aetna Medicare - H5522

For 2022, Aetna Medicare - H5522 received the following Star Ratings from Medicare:

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

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

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

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

Star Ratings are based on factors that include:

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

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

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

Y0001_GRP_2022_H5522_M

This page intentionally left blank.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Aetna Medicare - H7301

For 2022, Aetna Medicare - H7301 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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY).
Current members please call 888-267-2637 (toll-free) or 711 (TTY).

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

Y0001_GRP_2022_H7301_M

This page intentionally left blank.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Aetna Medicare - H9431

For 2022, Aetna Medicare - H9431 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.

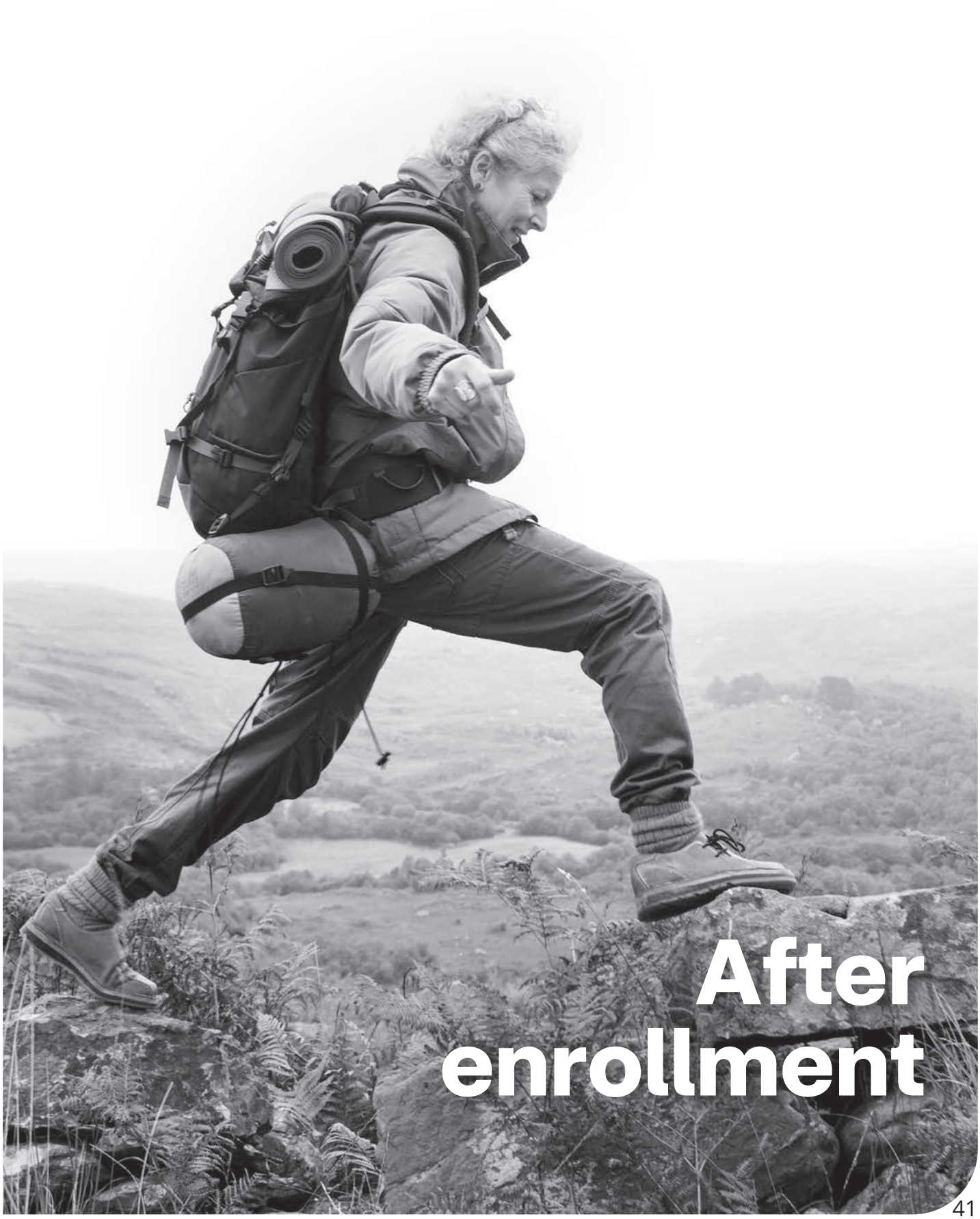
Questions about this plan?

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

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

Y0001_GRP_2022_H9431_M

This page intentionally left blank.



After enrollment

18.00.130.1_C

Start your journey off right

You'll hear from us within about 30 days after your enrollment in the plan.

Plan confirmation and acceptance letter

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

Plan member ID card

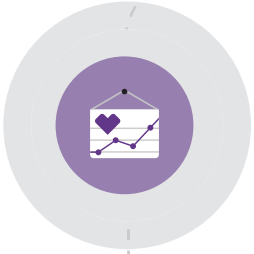
This card — not your red, white and blue Medicare card — should be used each time you visit the doctor, hospital or pharmacy (if you have prescription drug coverage). **You'll get your member ID card by mail. You can also find it online.**

Evidence of Coverage (EOC)

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

Formulary

This is a list of drugs your plan covers and any special requirements (if you have prescription drug coverage) with us. **You'll find your formulary online.**



Schedule of Cost Sharing (SOC)

This is the share of costs that you pay out of your own pocket. This can include deductibles, coinsurance, copayments or similar charges. **You'll get your SOC by mail. Depending on your plan, you'll also get instructions to find it online.**

Healthy Home Visit

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

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

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

You can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call **1-888-267-2637 (TTY: 711)**, 8 AM to 9 PM ET, Monday through Friday, if you do not receive your mail-order drugs within this time frame. Members may have the option to sign up for automated mail-order delivery.

Aetna Medicare's pharmacy network includes limited lower cost preferred pharmacies in: rural Nebraska, rural Kansas, suburban West Virginia, rural Maine, suburban Arizona, rural Michigan, urban Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call **1-855-338-7027 (TTY: 711)** or consult the online pharmacy directory at **AetnaMedicare.com/pharmacyhelp**.

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

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

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

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

Important information about your enrollment in a Medicare Advantage plan

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

18.28.328.1_C

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

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

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

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

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

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

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

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

Release of information

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

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-307-4830 (TTY: 711)**. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-307-4830 (TTY: 711)**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-800-307-4830 (TTY: 711)**。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-307-4830 (TTY: 711)**。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-307-4830 (TTY: 711)**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-307-4830 (TTY: 711)**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-307-4830 (TTY: 711)** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-307-4830 (TTY: 711)**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-307-4830 (TTY: 711)** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными

услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-307-4830 (TTY: 711)**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-307-4830 (TTY: 711)**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-307-4830 (TTY: 711)** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-307-4830 (TTY: 711)**. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-307-4830 (TTY: 711)**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-307-4830 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-307-4830 (TTY: 711)**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-800-307-4830 (TTY: 711)**にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma **1-800-307-4830 (TTY: 711)**. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

ID Y0001_NR_30475a_2023_C

18.32.3011-C3_C

Here for you

We're here to help answer your questions, so you can feel confident about your Medicare coverage. Check out the helpful resources on the next page.

Helpful resources

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

Give us a ring

Call us at 1-800-307-4830 (TTY : 711).
We're available 8 a.m. to 9 p.m. EST Monday Through Friday.

Websites to remember

Want more information about the plan and additional wellness programs? Looking for a doctor or hospital?

To find all that and more, visit aetnaretireeplans.com.

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

Write down your notes here

Write down your notes here


Thank you!

18.39.303.1_C (8/22)

aetna®