Aetna® Medicare benefits and enrollment guide

CENTRAL COAST PPO

PLANS:
Aetna Medicare Signature (PPO) - H5521-425
Aetna Medicare Enhanced (PPO) - H5521-478

* Signature is San Luis Obispo County
* Enhanced is Santa Barbara County

AetnaMedicare.com
Y0001_5671311_2026_M

aetna®

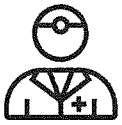
Plan premium, deductible, and maximum out-of-pocket (MOOP)

Out-of-pocket costs	
Monthly plan premium	$0 You must continue to pay your Medicare Part B premium.
Plan deductible	No in-network deductible. $500 for certain out-of-network services. Your deductible is what you'll pay before we begin to pay for services.
MOOP	$6,750 for in-network services $9,500 for in- and out-of-network services combined 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

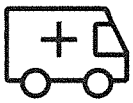
Hospital coverage
Your provider may need approval from us before we cover these services. This is called **prior authorization** or precertification.

Benefit	Your in-network costs	Your out-of-network costs
Inpatient (unlimited number of days)	$335 per day, days 1-7; $0 per day, days 8-90; $0 for additional days	50% per stay after your plan deductible is met
Outpatient hospital observation services	$335 copay	50% coinsurance after your plan deductible is met
Outpatient hospital	$375 copay	50% coinsurance after your plan deductible is met
Ambulatory surgical center	$325 copay	50% coinsurance after your plan deductible is met



Primary Care Provider (PCP) and specialist visits

Benefit	Your in-network costs	Your out-of-network costs
PCP	$0 copay	50% coinsurance after your plan deductible is met
Specialist	$50 copay	50% coinsurance after your plan deductible is met



Preventive, emergency and urgent care

Benefit	Your in-network costs	Your out-of-network costs
Preventive care	$0 copay For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.	0% - 50% coinsurance 0% coinsurance for the pneumonia, flu/influenza, hepatitis B, and COVID-19 vaccines 50% coinsurance for all other Medicare-covered preventive services
Emergency and urgent care (inside the U.S.)	$130 copay for emergency care $40 copay for urgent care	$130 copay for emergency care $40 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	$130 copay for emergency care $130 copay for urgent care $285 copay for ambulance Maximum coverage: $250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency ambulance)	$130 copay for emergency care $130 copay for urgent care $285 copay for ambulance

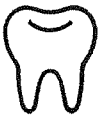
* www.AetnaMedicare.com/FindProvider

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 in-network costs	Your out-of-network costs
Diagnostic tests and procedures	$0 copay	50% coinsurance after your plan deductible is met
Lab services	$30 copay $0 copay for certain lab services including hemoglobin A1c, urine protein, prothrombin (protime), urine albumin, fecal immunochemical test (FIT), kidney health evaluation for members with diabetes (KED) and COVID-19 testing	50% coinsurance after your plan deductible is met
Diagnostic radiology services, such as CT/CAT scan and MRI	$200 copay	50% coinsurance after your plan deductible is met
Outpatient x-rays	$40 copay	50% coinsurance after your plan deductible is met

Hearing services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic hearing exam	$0 copay	50% coinsurance after your plan deductible is met
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.	50% coinsurance after your plan deductible is met
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. Even though you can go out-of-network for your annual hearing exam, this benefit amount can only be used to purchase hearing aids through a NationsHearing network provider.	Not Covered

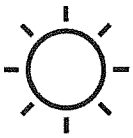


Dental services

Benefit	Your in-network costs	Your out-of-network costs
Dental services (non-Medicare covered)	$0 copay for preventive services	50% coinsurance for preventive services
	This benefit only covers preventive services. Preventive services include oral exams, x-rays, and cleanings. Comprehensive services are not covered. 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.	

Vision services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic eye exam (includes diabetic eye exams)	$0 copay	50% coinsurance after your plan deductible is met
Glaucoma screening	$0 copay	50% coinsurance after your plan deductible is met
Routine eye exam (one exam every year)	$0 copay with an EyeMed provider	0% coinsurance up to $50. You will be responsible for any billed amount over $50.
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $150 for covered prescription eyewear. We have teamed up with EyeMed to provide this benefit. You can choose to use a provider outside of the EyeMed network, but you may be responsible for additional costs. 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 in-network costs	Your out-of-network costs
Inpatient psychiatric hospital stay	$335 per day, days 1-6; $0 per day, days 7-90	50% per stay after your plan deductible is met
	Our plan covers up to 190 days per benefit period.	
Outpatient mental health therapy	$40 copay for individual sessions $40 copay for group sessions	50% coinsurance for individual sessions after your plan deductible is met 50% coinsurance for group sessions after your plan deductible is met
Outpatient psychiatric therapy	$40 copay for individual sessions $40 copay for group sessions	50% coinsurance for individual sessions after your plan deductible is met 50% coinsurance for group sessions after your plan deductible is met

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 in-network costs	Your out-of-network costs
SNF care	$10 per day, days 1-20; $218 per day, days 21-100	50% per stay after your plan deductible is met
	Our plan covers up to 100 days per benefit period.	
Physical and speech therapy	$30 copay	50% coinsurance after your plan deductible is met
Occupational therapy	$30 copay	50% coinsurance after your plan deductible is met

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 in-network costs	Your out-of-network costs
Ambulance (ground or air, one-way trip)	$285 copay for ground ambulance services 20% coinsurance for air ambulance services	$285 copay for ground ambulance services after your plan deductible is met 20% coinsurance for air ambulance services after your plan deductible is met
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 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	0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	50% coinsurance after your plan deductible is met
Part B Insulin	$35 copay	$35 copay after your plan deductible is met
Other Part B drugs	0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	50% coinsurance after your plan deductible is met

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 $0 - $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:

	Preferred Retail	Standard Retail	Preferred Mail	Standard Mail	Long-Term Care (LTC)
	30-day	**30-day**	**30-day**	**30-day**	**31-day**
Tier 1: Preferred Generic	$0	$2	$0	$2	$2
Tier 2: Generic	$0	$12	$0	$12	$12
Tier 3: Preferred Brand	24%	24%	24%	24%	24%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%
Tier 5: Specialty	25%	25%	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:

	Preferred Retail	Standard Retail	Preferred Mail	Standard Mail
	100-day	**100-day**	**100-day**	**100-day**
Tier 1: Preferred Generic	$0	$6	$0	$6
Tier 2: Generic	$0	$36	$0	$36
Tier 3: Preferred Brand	24%	24%	24%	24%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%
Tier 5: Specialty	A long-term supply is not available for drugs on Tier 5.			

Out-of-pocket threshold

$2,100 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

Alternative medicine

Benefit	Your in-network costs	Your out-of-network costs
Acupuncture	$50 copay for Medicare-covered acupuncture visits	50% coinsurance for Medicare-covered acupuncture visits after your plan deductible is met
	Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.	
Chiropractic services	$15 copay for Medicare-covered chiropractic visits	50% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met
	Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.	

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

Benefit	Your in-network costs	Your out-of-network costs
Diabetic supplies	0% - 20% coinsurance 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization	0% - 20% coinsurance after your plan deductible is met 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization

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 in-network costs	Your out-of-network costs
Foot exams and treatment	$50 copay for Medicare-covered podiatry visits	50% coinsurance for Medicare-covered podiatry visits after your plan deductible is met

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	$0 copay	50% coinsurance after your plan deductible is met

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, oxygen equipment, and continuous glucose monitors (CGMs)	0% - 20% coinsurance 0% coinsurance for continuous glucose monitors 20% coinsurance for all other Medicare-covered DME items	50% coinsurance after your plan deductible is met
Prosthetics, such as braces and artificial limbs	20% coinsurance	50% coinsurance after your plan deductible is met

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 in-network costs	Your out-of-network costs
Outpatient substance use disorder services	$40 copy for individual sessions $40 copy for group sessions	50% coinsurance for individual sessions after your plan deductible is met 50% coinsurance for group sessions after your plan deductible is met

Visitor/travel benefit
Plan rules continue to apply. **Prior authorizations** are required for certain services.

Benefit	
Visitor/travel program: Explorer	Allows you to remain in your plan for up to 12 months when you are outside our plan's service area. While traveling within the United States, you can see an Aetna Medicare participating provider and pay in-network cost shares. Not all providers participate in the multi-state network. In most cases, when you receive non-urgent/non-emergency care from an out-of-network provider, your share of the costs for your covered services may be higher. Contact us for help finding a participating provider in the area you're traveling to.

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

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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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Confirm your enrollment period

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:	Alan Kip Meredith
NPN#:	2594225

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

Choose your plan

Check the plan you want to enroll in.

☐ Aetna Medicare Signature (PPO) (H5521-425) S.C.O. **$0.00** per month

☐ Aetna Medicare Enhanced (PPO) (H5521-478) S. Barbera **$74.00** 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, Medical Group/Independent Practitioner Association (IPA), 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

Medical Group/IPA (located in the provider directory)

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.

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 Alan Kip Meredith	Relationship to enrollee Agent
Signature A. Meredith	National Producer Number (NPN) (Agents/Brokers only) 2594225

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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: Alan Kip Meredith

Phone number: 805 548 8672 | National Producer Number (NPN): 2594225

☐ 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 14088, Lexington, KY 40512
Fax: 1-866-756-5514

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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: Alan Kip Meredith	Agent Phone: 805 548-8672
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: M.A.P.D.	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.	