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Market-specific training for 2027 Great Lakes

January 2027

Before we begin

Important reminders

- You are not permitted to market or advertise 2027 plans or benefits until October 1, 2026 (even for October 1 sales events). And you must be ready to sell for 2027 before doing so.
- You cannot solicit or accept any enrollment application for 2027 plans prior to the start date of the Annual Election Period (AEP) on October 15.
- You're required to follow all Aetna® and Centers for Medicare & Medicaid (CMS) requirements when marketing or selling our products.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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How can your Great Lakes Market Associate help you?

Market Associates support brokers in their market with broker issues, assistance during market events, and perform trainings on broker systems.

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Broker Status	Aetna Tools	Commissions	Enrollment
• Annual certifications • Direct to market contract invitations • Individual and agency authorized contact updates • License and appointment requirements • Multi-factor authentication data • Contract changes and Notice of Intent/Transfer • Onboarding • Ready to sell (RTS) status	• Producer World, Aetna Marketing Portal, SilverScript Agent Portal, and AetnaMedicare.com • Plan-specific webpages and plan documents • Provider/Facility network status and provider directories • PCP and Provider identification numbers • Think Agent tools and registration	• Agent of Record* • Compensation • Updating EFT information instruction • HRA payments • Sales incentive payment research **Member initiated AOR changes cannot be submitted to Market Associates or Broker Managers. See Producer World for correct procedure for member initiated AOR requests.*	• MA/MAPD and PDP plan information • Plan benefit clarification • Member ID card replacement and temporary card production • National reciprocity clarification • Pending/denied applications • Application status • Broker attestation forms • D-SNP eligibility verification • Election period education

Market Associates cannot assist with member issues, including demographic updates, PCP changes, claims or billing issues, predeterminations, prior authorizations, reinstatements, Medicaid/LIS eligibility, late enrollment penalties, or premium issues. **Members should call the Customer Service number on the member ID card** for assistance with these items.

Market Associates cannot assist with Medicare Supplement questions or issues, including contracting, compensation, plan availability, enrollment eligibility, quotes, and premium payments. **Brokers should contact 866-272-6630 or AetSSIInformation@aetna.com** for Medicare Supplement support.

The Aetna advantage

High-quality plans, satisfied members and better retention — helping you build a stronger, more stable book of business.

Proven quality at scale

81% of Aetna MA members are in plans rated **4 Stars** or higher in 2026

63% of Aetna MA members are in a **4.5-Star** plan for 2026

Ranked **#1** among for-profit managed care organizations with over 250K Medicare members

Claim is based on 2026 Star Ratings data published by the Centers for Medicare & Medicaid Services on October 9, 2025, and MA and MAPD enrollment as of September 2025.

Aetna is proud to be named a 2026
"Best Medicare Advantage Company."

What members are saying:

> **"Aetna has worked well for both me and my wife. When either of us have questions, Aetna is there with the answers. And we've actually saved money!"**
>
> **– Aetna Medicare Member**

> **"The fact that an insurance provider is paying this close attention is amazing. Thank you Aetna for being proactive and invested in our health."**
>
> **– Aetna Medicare Member**

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Everything you need to sell, enroll and support members

Producer World®
Your go-to hub for tools, training and updates

Enrollment kits
Materials to support your sales conversations

AetnaMedicare.com for Producers
Plan info and sales support

ThinkAgent™
Digital tools to streamline the enrollment

Aetna Marketing Portal (AMP)
Order and customize marketing materials

Provider search tool
Help members find care that fits their needs

Producer Guide
Everything you need to know, all in one place

BenefitsCheckUp®
Help clients discover benefits they may qualify for

Aetna® Medicare website
Plan details, resources and support for members

IVL Medicare certification
Get certified for the upcoming plan year

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Digital enrollment on the go: Think Agent

Think Agent is a full stack electronic enrollment solution built for agents, featuring powerful sales tools to verify eligibility, shop plans, and enroll every Individual Aetna Medicare product.

Features include

- Six unique options to enroll
- All Aetna Medicare products
- Offline enrollment application
- Medicare number validation
- Medicaid and LIS eligibility verification
- Scope of Appointment by email or phone
- Search providers, drugs and pharmacies
- Ready-to-sell status verification

For assistance with registering, logging in, reporting or other technical issues, please email **Support@ThinkAgent.com** or call 1-866-714-9301 and select option #5.

Six options to enroll

Send for e-signature | Email kit (eKit) | Face-to-face | Video appointment | Personalized URL (PURL) | Phone (CARE)

How to get Think Agent

With a valid NPN, you can download the Think Agent app from the Apple and Google Play stores or visit **app.thinkagent.com** on your computer, and select “Sign up”

The following business day, you will receive two emails:

- Your username and a link to start registration
- Your registration PIN (case sensitive)

Follow the directions provided in the emails to finish your registration.

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Welcome Guide for new members

What to use when enrolling digitally

When enrolling through digital tools like **Think Agent**, full paper kits are not required.

Share the required documents electronically and provide a simplified **Welcome Guide with key highlights and QR codes.**

Key features

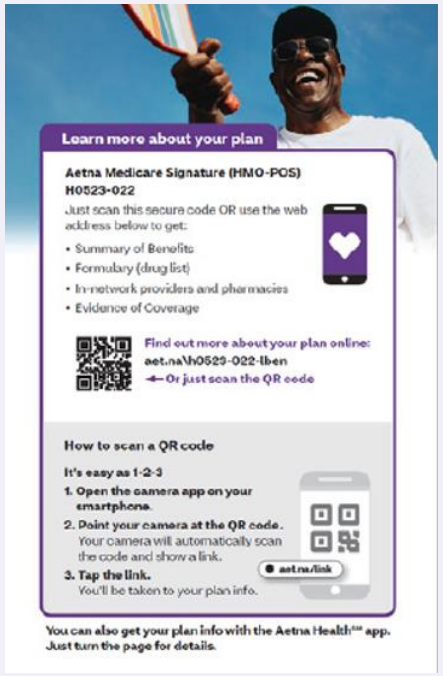
- Plan-specific version for every plan
- QR codes link to plan landing pages
- Essential phone numbers and websites
- Space for your contact info/business card
- Lightweight and portable

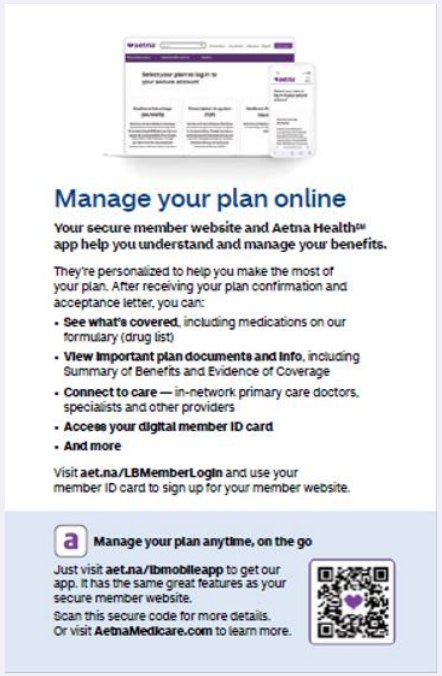
Ordering is simple

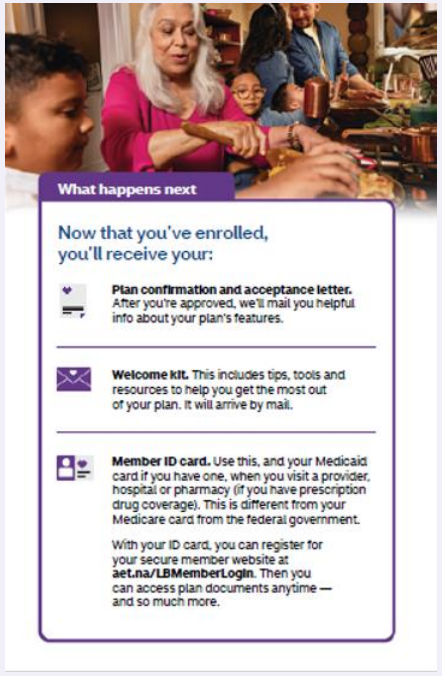
- Order from the same site as enrollment kits
- Available in English and Spanish

Paper enrollments still require full paper kits

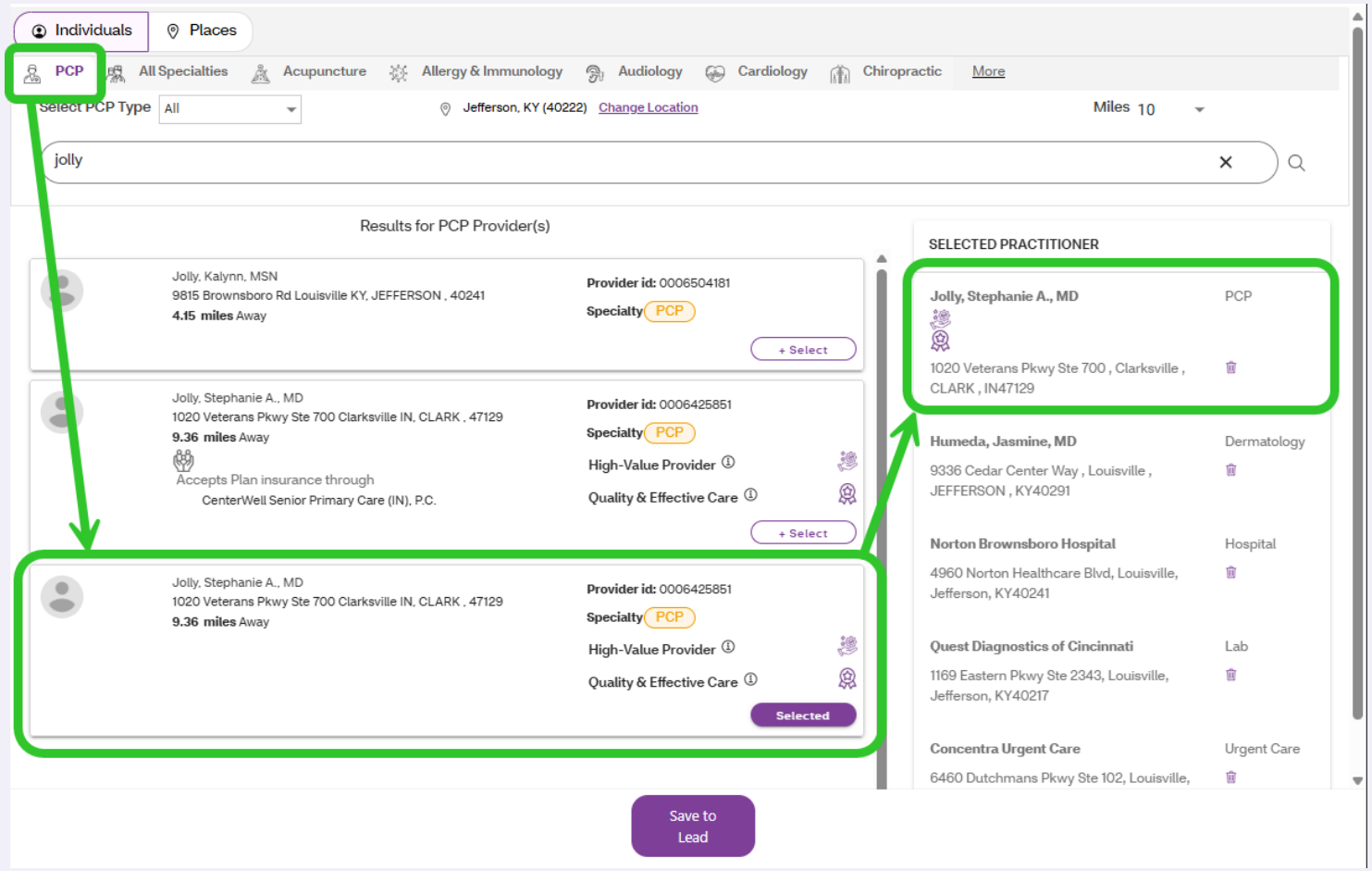
Inside each guide, you'll find helpful pages like these:







Adding a PCP in Think Agent



- In Think Agent, a PCP can be added **when creating a Lead**, which will then carry over to the enrollment application if the client is enrolled.
- Or, alternatively, you can skip adding it at the Lead stage and instead enter the PCP during the MA/MAPD **enrollment application** (on page 2 “Contact Information”).

PCP Selection Requirement

Primary Care Physician (PCP) selection is required on many 2027 Aetna Medicare plans (including some PPO plans). Help ensure your clients are connected to the right PCP.

If no PCP is selected on plans that require one, a PCP will be auto-assigned based on availability and proximity.

What brokers should do:

- Enter complete PCP details during enrollment:
  - PCP name
  - **Provider ID & Primary Care ID** (required)
  - **For IL FIDE:** When enrolling a prospective member in Think Agent, you must copy the provider NPI from the FIDE Provider Directory, and paste it directly on the Primary Care ID field
- Confirm the provider is a **valid PCP,** not a specialist
- Populate the **"current patient"** indicator when applicable

Why PCP Assignment Matters

- Helps members stay with their preferred provider
- Supports care coordination and better health outcomes
- If incorrect, member may need ID card reissued
- Incorrect PCPs can lead to complaints, grievances, or disenrollment

Services Fee for Brokers

EARN $15

Submit an enrollment **with an in-network PCP selected on a PCP required plan** – if the member stays enrolled for 90 days, **brokers earn $15.**

Auto-assigned PCPs do not qualify brokers for this services fee.

Health Risk Assessment (HRA)

An HRA is a quick post-enrollment survey that collects key health information from new SNP members so we can connect them with appropriate care and support programs early in their plan year.

How does it work?

- You enroll your client in a SNP* through Think Agent or another applicable electronic enrollment tool.
- After submitting the enrollment and before you close the application, you can initiate the HRA.
- Next, invite your client to participate in the HRA. They can consent or decline.
- The HRA takes less than 10 minutes, and you'll submit their answers.
- The survey must be completed in full to receive the administration payment.

*HRA payments are not available on HIDE and FIDE plans

Administrative fee

You can earn an administrative fee of **$50** each time you help one of these clients complete the HRA.

When is the deadline?

You can submit completed HRAs the same day you enroll your client or the next day (i.e., the day your client enrolls into a plan, plus one additional day).

Critical for SSBCI Eligibility in 2027: The HRA is one of the key data sources Aetna uses to verify SSBCI eligibility, including for the Extra Supports Wallet. It is important to make sure it is filled out ***completely, accurately***, and ***timely***.

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One Broker. One Broker Manager.

What's Changing

- **One accountable Broker Manager per Broker**
- Aetna's internal process for assigning a Broker to a Broker Manager will be based on their resident state, their RTS status and will go down to the county level
- Cross-market selling (no reassignment)

What this Means

Each Broker has:

- One clear relationship owner
- Consistent experience

Your Broker Manager will:

- Support you and your business no matter where you sell
- Support you as you expand into new markets

Why It Matters

- Creates clear accountability
- **Seamless broker experience across all markets**

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Agent of Record (AOR) Retention Policy

Your Value

We value the critical role you play in helping your clients understand their plan options and enroll in a plan that best meets their needs.

Our Promise

Our Agent of Record (AOR) retention policy reflects our ongoing commitment to you: **If your client enrolls in a new "like" plan, we will maintain your AOR status regardless of how they enroll** - by phone, online, by paper or directly with you.

Working Together

In member mailings, we will encourage members to **contact their agent for assistance first.**

If members choose to call Member Services or Aetna Telesales, we'll encourage those with an AOR to contact their agent for support. If they wish to proceed, we will assist them, **and you will remain the AOR.**

AOR Retention Conditions and Expectations

- You must be **ready-to-sell** at the time of the plan change.
- **AOR retention only applies to like-to-like plan changes** (e.g., MA-only, MAPD, or SNP). It does not apply when changing between product types (e.g., Individual/Family → MA, Med Supp → MA, or PDP → MA/MAPD). In those cases, you must submit a plan change to remain the AOR.
- If your client **enrolls with another agent, your AOR status will not be retained.**
- If your client's plan is nonrenewing effective December 31, and your client enrolls in a new plan after December 31, you must initiate the plan change to remain as the AOR.

Upcoming change to member-initiated AOR requests

Beginning September 1, **members will no longer be able to request an AOR change by calling Member Services.** Members who want to change their AOR must submit their request to directly to Aetna Medicare Broker Services through one of the following methods:

- Signed letter (handwritten or typed) mailed to: 620 Epsilon Drive, Pittsburgh, PA 15238
- Email: brokersupport@aetna.com

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Senior supplemental ancillary products

Your clients are unique — their coverage should be too.

We offer a complete portfolio of ancillary insurance products in our Protection Series℠ all supported by attentive customer service and prompt claims payments.

Mix and match from our ancillary product portfolio:

Hospital Indemnity Flex (Currently not in MI)
Daily hospital indemnity coverage including outpatient surgical, emergency room and other benefits that coordinate well with most Medicare Advantage programs.

Cancer and Heart Attack or Stroke Plus
Indemnity benefit for first occurrence cancer, heart attack or stroke events with recurrence coverage for individuals and families.

Dental, Vision and Hearing Flex/Plus
Additional coverage for dental, vision and hearing

Home Care Plus
Short-term recuperation indemnity product allowing members to recover at home with unskilled care or in the hospital, even under observation.

Recovery Care/Recovery Care Choice
Short-term recuperation indemnity product for use in the hospital, skilled nursing facility or assisted living facility.

Learn more at: AetnaSeniorProducts.com

Medicare Advantage Products

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Why sell an Aetna Medicare Eagle® plan?

Perfect for clients who don't need drug coverage but want rich supplemental benefits. Help them save while you grow your book.

These plans may be a great fit for:

- **Veterans (65+)** and spouses with VA Health Care or TRICARE for Life
- Individuals who receive prescription benefits through a **State Pharmaceutical Assistance Program (SPAP)** that does not require Part D coverage.
- Individuals who receive creditable drug coverage benefits through a **union or former employer.**
- Individuals **avoiding Part D late-enrollment penalties** but wanting comprehensive medical coverage.

Aetna Medicare Eagle® plans include these benefits & programs:


No premiums


Dental


Vision


Hearing

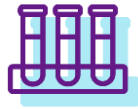

OTC


$0 PCP


Resources For Living®


24-hour Nurse Line


SilverSneakers® Fitness


$0 Lab cost share

Great Lakes's Aetna Medicare Eagle® plan includes a Part B premium reduction

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Why sell an Aetna Medicare Value plan?

These plans provide additional value for clients who receive Extra Help (LIS Subsidy) as well as additional coverage for clients who are willing to pay a low premium for richer benefits.

Value plans include these benefits & programs:

- No In-network Deductible
- $0 PCP
- Dental
- Vision
- Hearing
- OTC
- $0 T1 Preferred
- $0-$5 T2 Preferred
- Resources For Living®
- 24-Hour Nurse Line
- SilverSneakers® Fitness

Most Value plans also have...

- $0 Lab cost share

LIS-eligible members get even more benefits...

- $0 premium
- $0 Rx Deductible
- Reduced T2 Preferred Copay[1]
- Extra Supports Wallet[2]
- HVP Incentive Program[3]

[1] Tier 2 preferred copay applies lesser of logic between LIS Tier 2 amount and the filed copay

Individuals that are eligible for Extra Help and meet SSBCI eligibility criteria receive additional benefits:
[2] A Quarterly ESW allowance available on **Value Care** plans
[3] A HVP incentive, on **Value Care** plans, if members select a qualifying HVP as their PCP

Choosing the right network for the right member

HMO and PPO plans address different member needs. HMO plans emphasize coordinated, value-driven care through a local network, while PPO plans offer greater provider access and flexibility.

HMO: Best value when care stays local

- Designed to maximize value within a local provider network
- Supports stronger primary care coordination
- Often offers richer benefits and lower member cost sharing
- Typically provides more predictable out-of-pocket costs

Some HMO plans include expanded national access features; members should confirm provider availability before enrolling

PPO: Greater flexibility for broader access needs

- Provides broader provider access, typically with higher costs when using out-of-network care
- Well-suited for members who live, work, or receive care across multiple markets
- Delivers in-network savings while maintaining out-of-network options
- A strong choice for members willing to pay more for added flexibility and provider choice

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Essential benefits and programs

All plans include

Preventive Services: Annual wellness visits, Mammograms, Colonoscopies, Cardiovascular disease screenings, and more

Vaccine coverage: Members can get preventive vaccines like COVID-19, flu, pneumonia and shingles, at our large network pharmacies — often with no appointment and $0 cost share

Dental, Vision, and Hearing Benefits: Minimum of preventive dental on all plans, plus benefits for eyewear and hearing aid coverage

$0 Tier 1 Preferred Rx copay (MAPD plans): $0 copay at preferred pharmacies for Tier 1 drugs.

SilverSneakers®: SilverSneakers gives members access to fitness programs, gym memberships and wellness resources

Diabetic supplies & Continuous Glucose Monitors (CGMs):

- Blood glucose monitors and test strips are covered through **Accu-Chek/Roche** and **TRUE/Trividia.**
- CGMs, like **Dexcom** and **FreeStyle Libre**, are covered under Part B with up to 20% in-network cost.

Some plans have added benefits

Travel Advantage and Explorer

Travel Advantage (available on select HMO plans) and **Explorer** (available on PPO plans) allow members to remain outside their service area for up to 12 months. During this time, members can access Aetna's national network, pay in-network cost shares and must follow standard plan rules, including primary care physician (PCP) selection and referral requirements, where applicable.

Alternative medicine benefits

Medicare covers chiropractic care for spinal subluxation and acupuncture for chronic low-back pain. Some Aetna plans go further, offering additional routine chiropractic and acupuncture services beyond Medicare coverage.

Podiatry

Some plans offer 6, 12, or 24 visits annually for NMC Podiatry services.

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Care Beyond the Doctor's Office

Aetna surrounds the member with resources to improve care access, guidance, coordination and support outside of traditional physician visits. Extending care beyond the exam room, members can...

Get Guidance

24-Hour Nurse Line

For quick answers to health questions. The phone number is located on the back of the member's ID card.

Access Care

MinuteClinic® In-person and video visits

Members can schedule in-person or virtual care 24/7 via the website or CVS Health® app (available in 48 states).

Teladoc®

Provides telephonic or video visits for general medical needs, for the same cost as a PCP visit. Members will need to contact Teladoc directly to register.

Get Support

Care management team

Available on D-SNP and C-SNP plans, care managers work to coordinate services, support treatment plans, prevent complications, and close gaps in care. These programs are supported by nurses, social workers, pharmacists, behavioral health specialists, and dietitians who collaborate to manage and advocate for each member's care.

Healthy Home Visit program

signifyhealth

Allows our members to receive a non-invasive health exam and assessment performed by a licensed clinical provider, at no additional cost through **Signify Health**.

The Healthy Home Visit does not replace the member's PCP. Instead, it provides the member a chance to receive preventive care in addition to their annual PCP appointment.

Resources for Living

Connects members and their loved ones to local community resources – at no cost. Dedicated consultants can research and identify support for a wide range of topics and assist during stressful or emergency situations.

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Aetna Resources For Living® program

No-cost support

Connects members and their loved ones to local community resources – at no cost.

Saves time and reduces stress

Dedicated consultants can research and identify support for a wide range of topics, including:

- Senior housing and adult daycare
- Home-delivered meal options
- Caregiver support options
- Community transportation
- Activities at the local senior center

Help during urgent situations

Clients can call during stressful or emergency situations when they need help quickly, but don't have the ability or time to research on their own.

Members will need to schedule and pay for any services they decide to use.

Well-being coaching

Resources For Living also offers **one-on-one coaching at no added cost** to support your personal goals, such as improving physical wellness, building social connections, or focusing on personal growth.

Access for anyone

Fast access for anyone — the member, a spouse, child, grandchild, sibling or friend. Or you can call as their agent.

Available on all MA/MAPD, D-SNP and C-SNP plans.

Unbiased guidance

No financial ties to vendors. Referrals remain neutral and member-focused.

Easy to reach

Members can call Resources For Living at 866-370-4842 (TTY: 711), Monday through Friday, 8 AM to 8 PM ET.

Or they can call Member Services at the number on their member ID card and then ask to be transferred to Resources For Living.

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CY2027 Final Rule: Impacts to SSBCI Eligibility

CMS tightened how SSBCI eligibility is determined for 2027. This is an industry-wide change for all Medicare Advantage plans.

3-prong SSBCI Eligibility Requirements

To qualify for SSBCI benefits, members must meet <u>all three</u> requirements:

- Have one or more chronic condition(s) that are medically complex and life-threatening, or that greatly limit overall health or ability to function; **and**
- Are at high risk for going to the hospital or having other serious health problems; **and**
- Require a high level of care coordination

Additionally, each SSBCI benefit must have a reasonable expectation of improving or maintaining a member's health or overall function.

Key Changes

- **A chronic condition alone is not enough**
- **Self-attestation is no longer allowed**

What this means for Aetna plans:

- Extra Supports Wallet and the High Value Provider Incentive Program remain available in 2027
- Eligibility has changed, not the benefit itself
- **OTC wallets are not affected by SSBCI changes**

CY2027 Final Rule: Impacts to SSBCI Eligibility

The following represents the full set of objective eligibility criteria Aetna will use to determine if a member is eligible for SSBCI benefits*

Clinical Conditions and Diagnoses
- Member has a qualifying chronic or serious health condition (including behavioral health conditions)

Health Status and Functional Needs
- Member has identified difficulty with daily activities (like bathing, dressing, cooking, or managing medications) or overall health limitations.

Patterns of Care and Service Use
- Member regularly uses healthcare services or see multiple providers to manage their care.

Medication and Treatment Complexity
- Member takes multiple medications or follow complex treatment plans.

Changes in Health or Disease Progression
- Members' condition has been identified by their provider or care team as progressing or becoming more complex, and they may benefit from additional support.

Care Management Or Clinician Review
- Members' care team, or provider has identified that they may benefit from additional services.

Health-related Social Needs And Access Barriers
- Member has identified challenges that make it harder to stay healthy or get care—such as access to food, housing, or transportation.

***Some SSBCI benefits have additional eligibility requirements (ex: member must receive Extra Help)**

CY2027 Final Rule: Impacts to SSBCI Eligibility

Eligibility is based on objective, verifiable sources of clinical and health information from:

- Health risk assessments (HRA)
- Annual Wellness Visits (AWV)
- In-home or Healthy Home Visits
- Care management assessments
- Clinical evaluations and provider documentation (i.e., Provider Attestation)
- Claims data and other available health-related information

Important Note

Eligibility is based on documented clinical and health information.

It cannot be determined by requesting services or self-reporting.

No single criterion guarantees eligibility. Determinations are based on a combination of these criteria.

CY2027 Final Rule: Impacts to SSBCI Eligibility

How You Can Help

- Complete the **Health Risk Assessments (HRA)**
- Encourage members to see their **PCP**
- Educate clients on **Healthy Home Visits** available through Signify Health
- SNP members may be contacted by a **Care Manager** who can provide support and help coordinate their care.
    - Encourage members to answer calls from their health plan so they don't miss important healthcare information, services, and support.

Member Notification

Current Aetna Members will receive SSBCI eligibility letters in October notifying them of their 2027 status.

Look for more information on notification of your member's 2027 SSBCI status.

Extra Benefits Card wallets

Most plans will have an Extra Benefits Card with either the CVS OTC Wallet or OTC Wallet.

CVS OTC Wallet

OTC health and wellness products

Members can purchase products in store at any **CVS retail location** (excluding locations inside other stores) and online or by phone through **CVS Flex Benefits.**

OTC Wallet

OTC health and wellness products

Members can purchase products in store at **participating retail locations including CVS® retail stores** (excluding locations inside other stores) and online or by phone through **CVS Flex Benefits.**

Participating retail stores for the OTC Wallet

And More! Key retailers possibly coming in 2027: Weiss, Target & 7 Eleven

Our network of participating retail stores is **BIG**, with over **70,000 locations nationwide.**

Select plans in Michigan and Indiana have an OTC allowance not on an Extra Benefits card but through OTC Health Solutions.

Extra Benefits Card wallets

One Extra Benefits Card may include one or more wallets depending on the plan.

Extra Supports Wallet (ESW)

- **Healthy foods**
- **OTC**
- **Transportation**
- **Utilities**
- **Personal care products**

Members must meet certain eligibility criteria to qualify for this wallet.

Extra Supports HVP Wallet

Eligible members who receive the Extra Supports Wallet and select a qualifying HVP (high value provider), receive **$30 in their Extra Supports HVP Wallet** for healthy foods, OTC, personal care products, transportation, and utilities.

Members must meet certain eligibility criteria to qualify for this wallet.

Medical Expense Wallet

Out-of-pocket medical expenses

- Copays/coinsurance for plan covered services
- Additional visits for a plan-covered service that has a visit limit

Our network of participating retail stores is **BIG**, with over **70,000 locations nationwide.**

Participating retail stores for the ESW Wallet

CVS pharmacy, Walmart, Kroger, giant eagle, Sam's Club, Albertsons, Family Dollar, Dollar General, Costco Wholesale

And More! Key retailers possibly coming in 2027: Weiss, Target & 7 Eleven

NEW 7/1/2026:

Fresh, prepared meals delivery offered through **Nations Meals** on Extra Supports Wallet

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Extra Supports Wallet eligibility

The Extra Supports Wallet is a Special Supplemental Benefits for the Chronically Ill (SSBCI) benefit. Determine eligibility requirements for the Extra Supports Wallets (ESW) for each plan type

Plan type	Eligibility criteria	Determination process
General Enrollment (GE) plans (except Value plans)	**3-prong SSBCI eligibility:** ✓ Qualifying chronic condition; and ✓ High risk of hospitalization or adverse health outcomes; and ✓ Intensive care coordination required	• **New members** qualify via data-mined 3-prong SSBCI eligibility criteria and provider attestation. • **Renewing members** qualify via data-mined 3-prong SSBCI eligibility criteria.
Aetna Medicare Value plans (Plus/Care)	**3-prong SSBCI eligibility** **+ Extra Help**	• **New members** qualify via Extra Help status + data-mined 3-prong SSBCI eligibility criteria and provider attestation. • **Renewing members** qualify via Extra Help status + data-mined 3-prong SSBCI eligibility criteria.
SNP plans (D-SNP, HIDE, FIDE & C-SNP)	**3-prong SSBCI eligibility**	**Members transition from an OTC wallet to the ESW once SSBCI criteria is met.** • **New members** qualify via data-mined 3-prong SSBCI eligibility criteria and provider attestation. • **Renewing members** qualify via data-mined 3-prong SSBCI eligibility criteria.

High-value provider incentive program (HVPIP)

Aetna® Medicare offers $30 in their Extra Supports HVP Wallet to eligible members on select plans who meet certain criteria.

High-value providers (HVPs) are those designated by Aetna as being providers who are focused on excellence in primary care for older adults and others with chronic conditions.

To qualify for HVPIP, members must meet certain criteria:

- Qualify to get the Extra Supports Wallet (SSBCI); and
- Select an HVP as their PCP of record
- **Value Plans (Care or Plus in name): members must **also** receive any level of Low-Income Subsidy (LIS), also known as Extra Help*

Eligible members receive **$30 in their Extra Supports HVP Wallet,** loaded on their Extra Benefits Card.

- **GE plans**: $30/quarter Extra Supports HVP Wallet dollars **and** cost-share reductions ($10 specialists, $0 routine behavioral health, $0 select diagnostics)
- **SNPs:** $30/month Extra Supports HVP Wallet dollars

Participating HVPs:

Oak Street Health

CenterWell

Sage Health

ChenMed

Dedicated Senior Medical Center
A CHENMED COMPANY

JenCare Senior Medical Center

One Medical

ArchWell HEALTH

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Dental, vision and hearing designs

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Supplemental Vision benefit:

EyeMed

All Aetna plans with EyeMed include the following:

- One annual routine eye exam and one refraction, plus an annual allowance for prescription eyewear, including glasses and contact lenses.
- Annual allowances vary by plan. Any amount over the allowance will be paid by the member at point of sale.
- **Out-of-network benefits are available on PPO plans only**. PPO members may save on routine eye exams and refractions by seeing an in-network provider.
    - Out of network benefits may need to be reimbursed to the member if their OON provider does not bill EyeMed

Aetna members can schedule appointments with any of EyeMed's vision providers. To find an in-network vision provider, members can visit **AetnaMedicareVision.com** or call the phone number on their ID card.

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Hearing aid benefit:

NationsHearing allowance benefit

NationsHearing hearing aid benefit — allowance

NationsHearing provides coverage for **one annual non-Medicare-covered (NMC) routine hearing exam and fitting at a $0 copay.**

Members receive coverage up to their **annual allowance amount toward the purchase of hearing aids.**

Hearing aids must be purchased through our exclusive vendor, NationsHearing.

To schedule:

- **Call 1-877-225-0137** (Monday to Friday, 8 AM to 8 PM local time, excluding federal holidays)
- **Or visit NationsHearing.com/Aetna**

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Dental benefit: Deluxe Dental (Embedded)

What's covered

This design covers routine preventive dental services plus additional comprehensive services with member cost sharing.

Comprehensive services include crowns, bridges, dentures, the removal of impacted teeth and general anesthesia.

Annual allowance limits vary by plan and frequency limits apply to services. Preventive services do not accrue toward annual allowance limits, only comprehensive services accrue.

Frequency limits, medical necessity review, claim edits and alternate benefits apply to covered services.

Dental network options

In-network (INN) only options:

- Deluxe EPO mandatory
- Deluxe EPO mandatory 50

INN and out-of-network (OON) coverage options:

- Deluxe EPO POS mandatory
- Deluxe PPO mandatory
- Deluxe PPO mandatory 50/30

Member pays

INN coverage:

- **Preventive Services**: all Deluxe designs have $0 member copay for covered preventive services
- **Comprehensive Services:** Deluxe designs have 20% to 50% or flat 50% member coinsurance for covered comprehensive services, depending on the design

OON coverage (where offered):

- **Preventive Services:** all Deluxe designs have 50% member coinsurance for covered preventive services
- **Comprehensive Services:** Deluxe designs have 50% to 70% or flat 70% member coinsurance for covered comprehensive services, depending on the design

Dental benefit: Essential Dental

What's covered

This design covers most ADA-recognized dental services, excluding implants, orthodontics, cosmetic services, those considered medical in nature and administrative charges.

Annual allowance limits vary by plan. Both preventive and comprehensive services accrue toward the annual allowance.

Medical necessity review, claim edits and alternate benefits apply to covered services.

Dental network options

In-Network (INN) and out-of-network (OON) coverage options:

- Essential EPO POS 100/80

Member pays

INN coverage:

- $0 member copay for covered services

OON coverage (where offered):

- 20% member coinsurance for covered services

Dental benefit: Enhanced SNP Dental

What's covered

This design covers most ADA-recognized dental services, excluding implants, orthodontics, cosmetic services, those considered medical in nature and administrative charges.

Annual allowance limits vary by plan. Both preventive and comprehensive services accrue toward the annual allowance.

Frequency limits, medical necessity review, claim edits and alternate benefits apply to covered services.

Dental network options

In-network (INN) only options:

- Enhanced SNP EPO mandatory

Member pays

INN coverage:

- $0 member copay for covered services

Dental benefit: DentaQuest Dental

What's covered

DentaQuest Dental Plan administers dental embedded (mandatory) benefits with a schedule of covered services for a subset of plans in IL and MI. This includes preventive services such as (but not limited to) exams, X-rays and cleanings as well as comprehensive services such as (but not limited to) crowns, fillings, root canals and dentures.

Members are covered at $0 for covered services when using an INN provider with limitations, frequencies and prior authorization on some dental services.

Annual allowance limits vary by plan.

Dental network options

In-network (INN) only options:

- DentaQuest Enhanced Wrap MI
- DentaQuest Enhanced IL*

*IL: Certain Medicaid covered dental services will now accrue toward the member's Medicare supplemental dental annual maximum.

Member pays

INN coverage:

- $0 member copay for covered services

OON coverage:

- These plans do not offer OON coverage. Members are responsible for 100% of charges if they use an OON provider.

Members may call DentaQuest Member Services for assistance at:

- IL FIDE: 1-800-416-9185
- MI HIDE: 1-844-870-3976

And can search the DentaQuest online provider directory to locate a network providers at **http://dentaquest.com/en/find-a-dentist**

2027 plan changes

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Plan terminations & SARs

Be sure you're talking to your clients before AEP kicks-off, so they know who to contact if they experience any plan changes for 2027.

Plan Terminations: Plan ends 12/31 and will not be offered in 2027

Plan SARs: Plan remains, but no longer available in certain counties for 2027

Member Impact:

- Impacted members will receive notification from Aetna and CMS that their plan will not be offered in 2027
- If no action is taken, impacted members will default to Original Medicare
- Members have AEP and a Special Election Period (12/8 – 2/28) to enroll into a new plan

Broker action: Proactively outreach your clients to ensure members transition to appropriate coverage and avoid gaps.

2027 Michigan plan terminations

2026 PBP	2026 Plan name	2026 County Footprint
H3192-021	**Aetna Medicare Prime Care (HMO-POS)**	Genesee, Macomb, Oakland, Wayne
H5521-607	**Aetna Medicare Enhanced (PPO)**	Barry, Branch, Calhoun, Clinton, Eaton, Genesee, Hillsdale, Ingham, Ionia, Jackson, Kalamazoo, Kent, Lake, Lenawee, Livingston, Macomb, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oakland, Osceola, Ottawa, Shiawassee, St. Clair, Van Buren, Washtenaw, Wayne

2027 Michigan service area reductions (SARs)

2027 Plan + Contract PBP	2027 County Footprint	2027 Exited Counties
Aetna Medicare Dual Care (HMO D-SNP) H3192-007	Allegan, Clinton, Eaton, Genesee, Hillsdale, Huron, Ingham, Ionia, Jackson, Kent, Lake, Lapeer, Lenawee, Livingston, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw	Antrim, Arenac, Bay, Benzie, Charlevoix, Crawford, Emmet, Gladwin, Grand Traverse, Gratiot, Kalkaska, Leelanau, Manistee, Missaukee, Ogemaw, Otsego, Roscommon, Saginaw, Wexford
Aetna Medicare Signature (PPO) H5521-285	Arenac, Bay, Benzie, Crawford, Delta, Dickinson, Emmet, Grand Traverse, Gratiot, Kalkaska, Manistee, Marquette, Menominee, Missaukee, Roscommon, Saginaw, Sanilac, Tuscola, Wexford	Alger, Antrim, Baraga, Charlevoix, Houghton, Iron, Keweenaw, Leelanau, Luce, Ontonagon, Otsego
Aetna Medicare Eagle (PPO) H5521-286	Many counties across IL, IN, MI & WI	IN-Cass, IN-Daviess, IN-Gibson, IN-Pike, IN-Pulaski, MI-Alger, MI-Antrim, MI-Baraga, MI-Charlevoix, MI-Houghton, MI-Iron, MI-Keweenaw, MI-Leelanau, MI-Luce, MI-Ontonagon, MI-Otsego

MICHIGAN | PDP

Plan Name	Silverscript Choice (PDP) S5601-026
Premium	$100.50
Deductible (all tiers)	$700
RX MOOP	$2,400
Tier 1 - Standard Retail	$0
Tier 2 - Standard Retail	$7
Tier 3 - Standard Retail	23%
Tier 4 - Standard Retail	34%
Tier 5 - Standard Retail	25%
Covered Insulins	$35

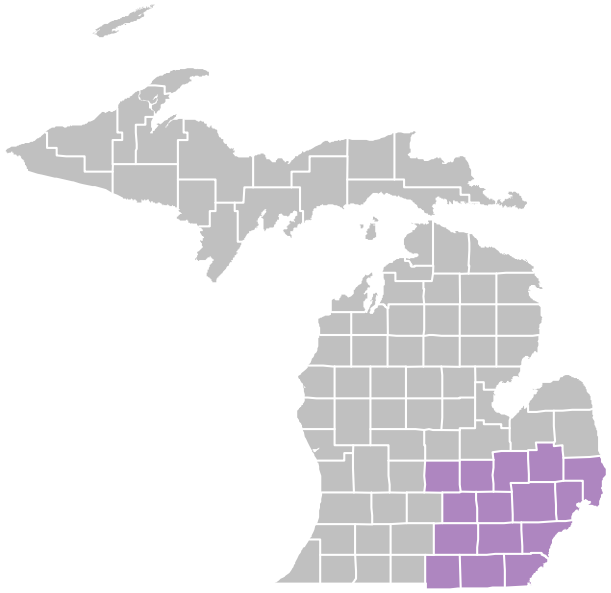
Submarket highlights

Great Lakes

MI Southeast

Medicare eligibles:

1,034,855



Service area:

Clinton, Genesee, Hillsdale, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Shiawassee, Washtenaw, Wayne

Current

4+ Star Ratings — 2026

Contract	2026 Star Rating
H5521	★★★★½

Reflects 2026 CMS annual Star Ratings for quality and service performance.

Network highlights

- ✓ Oak Street Health
- ✓ Dedicated Physicians Group of Michigan
- ✓ Henry Ford Health
- ✓ McLaren Health
- ✓ St. John Hospital
- ✓ Corewell Health
- ✓ University of Michigan
- ✓ Trinity Health
- ✓ Genesys Regional Hurley Medical Center
- ✓ Oaklawn Hospital
- ✓ Hillsdale Hospital
- ✓ ProMedica Monroe
- ✓ Covenant Medical Center

Plus, access to Aetna's national network on most plans.
Consult the online provider directory for full list of providers.

MI Southeast submarket insights

- **11.9%** market share of Medicare Advantage population
- **59,871** enrolled in Aetna Medicare Advantage plans
- **9,758** newly enrolled in 2026 AEP

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MICHIGAN | PPO

LEAD PLAN

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Plan Name	Aetna Medicare Signature (PPO) H5521-214
County Footprint	**Clinton, Genesee, Hillsdale, Ingham, Jackson, Lenawee, Livingston, Macomb, Oakland, Shiawassee, St. Clair, Washtenaw, Wayne**
Monthly Premium	$0
Part B Giveback	None
PCP Selection & Referrals	PCP selection is not required; Referrals are not required
In-Network Deductible	$0
In-Network MOOP	$5,200
In-Network PCP	$0
In-Network Specialist	$40
Inpatient Hospital Stay	$295 per day, days 1-7; $0 per day, days 8-90
Outpatient Hospital	$35 - $295
Quarterly OTC Allowance	All members receive a **$75 quarterly allowance loaded to their Extra Benefits Card (EBC) - OTC Wallet** to help cover approved OTC products.
Annual Dental Allowance	$2,500 - Deluxe PPO Mandatory
Annual Eyewear Allowance	$175 - EyeMed
Annual Hearing Allowance	$1,500 per ear
RX Deductible	$400 (tiers 3-5)
Retail Drug One-Month	T1 $0 | T2 $0 | T3 13% | T4 30% | T5 29%

MICHIGAN | PPO

Plan Name	Aetna Medicare Signature Extra (PPO) H5521-404
County Footprint	**Clinton, Genesee, Hillsdale, Ingham, Jackson, Lenawee, Livingston, Macomb, Oakland, Shiawassee, St. Clair, Washtenaw, Wayne**
Monthly Premium	$0
Part B Giveback	None
PCP Selection & Referrals	PCP selection is not required; Referrals are not required
In-Network Deductible	$0
In-Network MOOP	$4,900
In-Network PCP	$0
In-Network Specialist	$40
Inpatient Hospital Stay	$300 per day, days 1-8; $0 per day, days 9-90
Outpatient Hospital	$35 - $300
Quarterly OTC Allowance	All members receive a **$60 quarterly allowance loaded to their Extra Benefits Card (EBC) - CVS OTC Wallet** to help cover approved OTC products.
Annual Dental Allowance	$2,000 - Deluxe PPO Mandatory
Annual Eyewear Allowance	$175 - EyeMed
Annual Hearing Allowance	$1,000 per ear
RX Deductible	$500 (tiers 3-5)
Retail Drug One-Month	T1 $0 | T2 $5 | T3 17% | T4 28% | T5 28%

MICHIGAN | PPO

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Plan Name	Aetna Medicare Value Care (PPO) H5521-399
County Footprint	**Clinton, Genesee, Hillsdale, Ingham, Jackson, Lenawee, Livingston, Macomb, Oakland, Shiawassee, St. Clair, Washtenaw, Wayne**
Monthly Premium	$0
Part B Giveback	None
PCP Selection & Referrals	PCP selection is not required; Referrals are not required
In-Network Deductible	$0
In-Network MOOP	$5,900
In-Network PCP	$0
In-Network Specialist	$20
Inpatient Hospital Stay	$300 per day, days 1-7; $0 per day, days 8-90
Outpatient Hospital	$20 - $300
Quarterly OTC Allowance	All members receive a **$100 quarterly allowance loaded to their Extra Benefits Card (EBC) - OTC Wallet** to help cover approved OTC products. Members who **meet the 3-prong SSBCI eligibility and have Extra Help also get a $30 quarterly allowance loaded to their EBC - Extra Supports Wallet (ESW)** to help pay for certain everyday expenses, including healthy foods, OTC products, personal care products, transportation and utilities. **SSBCI & Extra Help qualified members who select a HVP as their PCP will also get a $30 quarterly allowance loaded to their EBC – Extra Supports HVP Wallet.**
Annual Dental Allowance	$2,750 - Deluxe PPO Mandatory
Annual Eyewear Allowance	$250 - EyeMed
Annual Hearing Allowance	$1,250 per ear
RX Deductible	$400 (tiers 3-5)
Retail Drug One-Month	T1 $0 | T2 $0 | T3 13% | T4 30% | T5 29%

MICHIGAN | HMO-POS

Plan Name	Aetna Medicare Signature (HMO-POS) H3192-003
County Footprint	**Clinton, Genesee, Hillsdale, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Shiawassee, St. Clair, Washtenaw, Wayne**
Monthly Premium	$0
Part B Giveback	None
PCP Selection & Referrals	PCP selection is required; Referrals are not required
In-Network Deductible	$0
In-Network MOOP	$6,750
In-Network PCP	$0
In-Network Specialist	$45
Inpatient Hospital Stay	$350 per day, days 1-7; $0 per day, days 8-90
Outpatient Hospital	$0 - $350
Quarterly OTC Allowance	All members receive a **$15 quarterly allowance loaded to their Extra Benefits Card (EBC) - CVS OTC Wallet** to help cover approved OTC products.
Annual Dental Allowance	$1,000 - Deluxe EPO POS Mandatory
Annual Eyewear Allowance	$100 - EyeMed
Annual Hearing Allowance	$500 per ear
RX Deductible	$500 (tiers 3-5)
Retail Drug One-Month	T1 $0 | T2 $5 | T3 17% | T4 28% | T5 28%

GREAT LAKES | MA-Only

Plan Name	Aetna Medicare Eagle (PPO) H5521-286
County Footprint	**Illinois:** Boone, Bureau, Cook, DeKalb, DuPage, Grundy, Henderson, Henry, Jo Daviess, Kane, Kankakee, Kendall, Lake, Lee, McHenry, Ogle, Rock Island, Stephenson, Whiteside, Will, Winnebago **Indiana:** Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Clay, De Kalb, Dubois, Elkhart, Floyd, Franklin, Fulton, Greene, Hamilton, Hancock, Hendricks, Huntington, Jasper, Jay, Johnson, Knox, La Porte, Lake, Madison, Marion, Marshall, Martin, Miami, Montgomery, Newton, Orange, Parke, Posey, Putnam, Shelby, Spencer, St. Joseph, Starke, Sullivan, Wabash, Washington, Whitley **Michigan:** Arenac, Barry, Bay, Benzie, Branch, Calhoun, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Genesee, Grand Traverse, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lenawee, Livingston, Macomb, Manistee, Marquette, Mason, Mecosta, Menominee, Missaukee, Montcalm, Muskegon, Newaygo, Oakland, Osceola, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Van Buren, Washtenaw, Wayne, Wexford **Wisconsin:** Adams, Brown, Columbia, Dane, Florence, Forest, Green, Iowa, Kenosha, Kewaunee, La Crosse, Lafayette, Langlade, Manitowoc, Marinette, Marquette, Milwaukee, Monroe, Oconto, Outagamie, Ozaukee, Portage, Racine, Rock, Shawano, Sheboygan, Trempealeau, Vernon, Washington, Waukesha, Waushara, Winnebago
Monthly Premium	$0
Part B Giveback	$70
PCP Selection & Referrals	PCP selection is not required; Referrals are not required
In-Network Deductible	$0
In-Network MOOP	$5,200
In-Network PCP	$0
In-Network Specialist	$40
Inpatient Hospital Stay	$300 per day, days 1-6; $0 per day, days 7-90
Outpatient Hospital	$40 - $300
Quarterly OTC Allowance	All members receive a **$100 quarterly allowance loaded to their Extra Benefits Card (EBC) - CVS OTC Wallet** to help cover approved OTC products.
Annual Dental Allowance	$3,750 - Essential PPO 100/80
Annual Eyewear Allowance	$300 - EyeMed
Annual Hearing Allowance	$1,250 per ear

Dual Eligible Special Needs Plans (D-SNPs)

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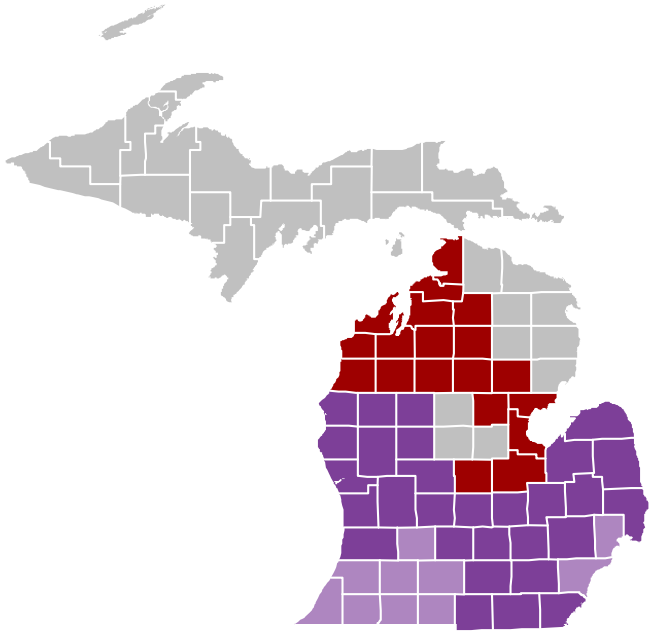
Michigan D-SNP service area

All D-SNP county map



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

FBDE | QMB+ | SLMB+ | QMB

County Footprint: Allegan, Clinton, Eaton, Genesee, Hillsdale, Huron, Ingham, Ionia, Jackson, Kent, Lake, Lapeer, Lenawee, Livingston, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw

Aetna Medicare HIDE (HMO D-SNP) H9314-001:

FBDE | QMB+ | SLMB+

County Footprint: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne

SAR counties

Dual Eligible Special Needs Plans (D-SNPs)

Key benefits and programs on D-SNPs include:

No premiums

Dental

Vision

Hearing

$0 (tier 1) or $0 (tier 1/tier 2)

$0 PCP

OTC

SilverSneakers® Fitness

Fall prevention

Personal Emergency Response System

Care management

Post-discharge meals

Resources For Living®

Extra Benefits Card (EBC)

All D-SNP members get a **monthly OTC Wallet on an Extra Benefits Card** for approved over-the-counter items.

OTC Wallet upgrades to an **Extra Supports Wallet**, when members meet 3-prong SSBCI eligibility, which adds spending categories beyond OTC, including:

- Healthy food
- Transportation
- Utilities
- Personal care supplies
- OTC

HVPIP: Eligible members receive $30 on Extra Supports HVP Wallet when they select a qualified high-value provider.*

**Care in a D-SNP plan name indicates HVPIP allowance available.*

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Review of D-SNP Category Types

Plan	Category Type	Definition	Benefits
Coordination Only (H3192-007)	**Qualified Medicare Beneficiary Only (QMB)**	Individuals who have Medicare Part A, income at or below 100% of the federal poverty level (FPL), and resources no more than 2x the SSI limit.	Medicaid pays for: • Medicare premiums • Deductibles • Coinsurance • Copayments (excluding Medicare Part D)
Coordination Only (H3192-007) **AND** **HIDE (H9314-001)**	**Qualified Medicare Beneficiary Plus (QMB+)**	Individuals must meet QMB eligibility criteria (Medicare Part A, income ≤ 100% FPL, resources ≤ 2x SSI limit) while also meeting full Medicaid eligibility requirements	Receive all QMB Medicaid Benefits, including: • Medicare premiums • Deductibles • Coinsurance • Copayments (excluding Medicare Part D) • Plus, full Medicaid State Plan benefits (e.g., medical services, long-term care, additional supports)
	Specified Low-Income Medicare Beneficiary Plus (SLMB+)	Individuals who have Medicare Part A, income between 100% and 120% of the FPL, resources no more than 2x the SSI limit, while also meeting the full Medicaid eligibility requirements. SLMBs who meet the standards for SLMB eligibility, but who also meet the criteria for full Medicaid coverage.	Medicaid pays for: • Medicare Part B premium • Full Medicaid State Plan benefits (e.g., medical services, long-term care, additional supports)
	Full Benefit Dual Eligible (FBDE / Medicaid Only)	Individuals who do not qualify for QMB or SLMB, are eligible for Medicaid through: • Categorical eligibility • Medically needy programs • Institutional care income levels • Home & community-based waiver programs	Medicaid pays for: • Medicare premiums • Deductibles • Coinsurance • Copayments (excluding Medicare Part D)

Medicare and Medicaid Alignment – Michigan Coordination Only

Coordination Only (CO) D-SNP:

- Covers **Medicare Benefits Only**
- Does not manage Medicaid Benefits
- Member can keep a separate Medicaid MCO
- **Medicare and Medicaid are NOT integrated**

Managed Care Organization (MCO):

- Covers **Medicaid benefits only**
- Beneficiaries select their MCO, those who do not will be auto assigned by MI Enrolls.

When a member's D-SNP and Medicaid MCO do not "line up" under the same parent company they are considered unaligned.

Important for Michigan:

- Michigan does not require Coordination Only enrollment to be aligned to the MCO.
- As a result, **H3192-007 can accept new members** (QMB, QMB+, SLMB+ & FBDE) that are with another MCO.

H3192-007: Enrolls QMB, QMB+, SLMB+ & FBDE

MICHIGAN | D-SNP

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Plan Name	Aetna Medicare Dual Care (HMO D-SNP) H3192-007
County Footprint	**Allegan, Clinton, Eaton, Genesee, Hillsdale, Huron, Ingham, Ionia, Jackson, Kent, Lake, Lapeer, Lenawee, Livingston, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw**
Monthly Premium	$0
PCP Selection & Referrals	PCP selection is required; Referrals are not required
In-Network PCP	20%
In-Network Specialist	20%
Monthly OTC Allowance	All members receive a **$191 monthly allowance loaded to their Extra Benefits Card (EBC) - OTC Wallet** to help cover approved OTC products. If a member **meets the 3-prong SSBCI eligibility, their OTC Wallet will upgrade to an Extra Supports Wallet (ESW)** to help pay for certain everyday expenses, including healthy foods, OTC products, personal care products, transportation and utilities. **SSBCI qualified members who select a HVP as their PCP will also get a $30 monthly allowance loaded to their EBC – Extra Supports HVP Wallet.**
Annual Dental Allowance	$2,000 - Enhanced SNP EPO Mandatory
Annual Eyewear Allowance	$250 - EyeMed
Annual Hearing Allowance	$1,000 per ear
Transportation	No
LIS/Extra Help: RX Deductible	$0
LIS/Extra Help: Generic Drugs	$0, $1.65 or $5.80
LIS/Extra Help: Brand Drugs	$0, $5.00 or $14.40

Medicare and Medicaid Alignment – Michigan HIDE

Aetna HIDE Enrollment & Medicaid Alignment

Step 1: Member has Medicare + Full Medicaid

↓

Step 2: Member elects Aetna HIDE D-SNP

↓

Step 3: State and plan establish aligned enrollment

↓

Step 4: Member receives integrated Medicare + Medicaid benefits through Aetna HIDE

The **HIDE-SNP** integrates long-term service and supports (LTSS) and provides all Medicare and most Medicaid covered benefits, but specialty Medicaid behavioral health services will remain carved out.

To enroll in Aetna's HIDE D-SNP, the member must:

- Be age 21+
- Have Medicare Parts A & B
- Receive **full Medicaid benefits**
- Live in the HIDE service area
- Not be actively enrolled in MI Choice or PACE programs

Important for Michigan:

- H9134-001 **can accept new members** (QMB+,SLMB+ & FBDE) that are with another MCO. MCO alignment will occur after HIDE enrollment.
- HIDE D-SNP allows for year-round enrollment.

Members enrolled in **MI Choice or PACE** must disenroll from these waiver programs **PRIOR** to enrolling in the HIDE plan.

MICHIGAN | HIDE D-SNP

Plan Name	Aetna Medicare HIDE (HMO D-SNP) H9314-001
County Footprint	**Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne**
Monthly Premium	$0
PCP Selection & Referrals	PCP selection is required; Referrals are not required
In-Network PCP	$0
In-Network Specialist	$0
Monthly OTC Allowance	All members receive a **$229 monthly allowance loaded to their Extra Benefits Card (EBC) - OTC Wallet** to help cover approved OTC products. If a member **meets the 3-prong SSBCI eligibility, their OTC Wallet will upgrade to an Extra Supports Wallet (ESW)** to help pay for certain everyday expenses, including healthy foods, OTC products, personal care products, transportation and utilities.
Annual Dental Allowance	$2,000 - DentaQuest Enhanced Wrap MI
Annual Eyewear Allowance	$250 - VSP
Annual Hearing Allowance	$1,500 per ear
Transportation	No
LIS/Extra Help: RX Deductible	$0
LIS/Extra Help: Generic Drugs	$0, $1.65 or $5.80
LIS/Extra Help: Brand Drugs	$0, $5.00 or $14.40

Chronic Condition Special Needs Plans (C-SNPs)

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Chronic Special Needs Plans (C-SNPs)

Aetna C-SNPs offer year-round enrollment, specialized coverage, tailored support and richer supplemental benefits compared to other general enrollment plans.

C-SNP Insights

- **80%** of Medicare beneficiaries live with at least **one chronic condition**
- Nearly **45%** of Medicare eligibles qualify for a C-SNP
- Many of them are not eligible for a D-SNP
- C-SNP members are more likely to stay enrolled and engaged
- Enhanced benefits and care coordination drive real value
- **86% of seniors have never heard of C-SNP**

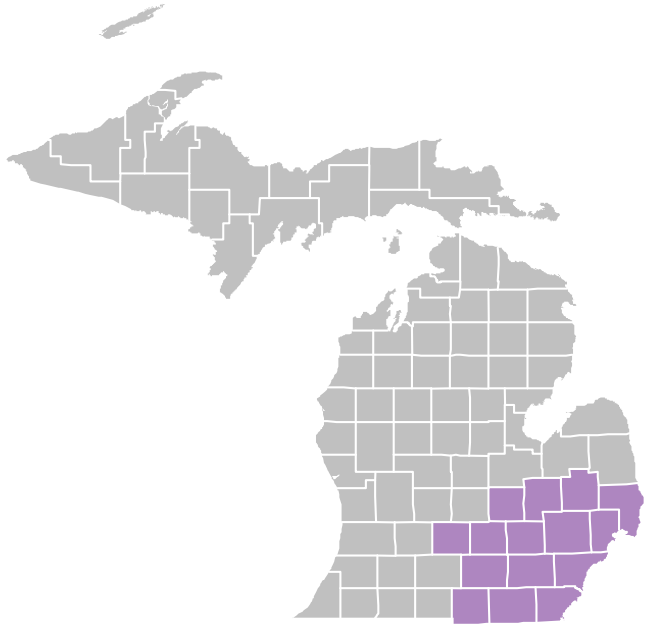
Source: Acxiom Infobase, MRI Simmons Spring 23, Morning Consult custom C-SNP Omnibus study April 2024

Medicare beneficiaries can enroll if they have at least one of these qualifying conditions:

- **Diabetes Mellitus** (high blood sugar)
- **Chronic Heart Failure** (CHF) (heart is unable to pump blood as it should)
- **Cardiac arrhythmias** (irregular heartbeats)
- **Coronary artery disease** (blocked blood vessels in the heart)
- **Peripheral vascular disease** (poor circulation in the arms and legs)
- **Valvular heart disease** (damage of flaps in the heart that control blood flow)

Michigan C-SNP plan availability

C-SNP county map



Chronic Care C-SNP

For members with an eligible chronic condition.

Aetna Medicare Chronic Care (HMO C-SNP) H3192-003

County Footprint: Clinton, Genesee, Hillsdale, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Shiawassee, St. Clair, Washtenaw, Wayne

MICHIGAN | C-SNP

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Plan Name	Aetna Medicare Chronic Care (HMO C-SNP) H3192-033
County Footprint	**Clinton, Genesee, Hillsdale, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Shiawassee, St. Clair, Washtenaw, Wayne**
Monthly Premium	$0
PCP Selection & Referrals	PCP selection is required; Referrals are not required
In-Network Deductible	$0
In-Network MOOP	$7,150
In-Network PCP	$0
In-Network Specialist	$0 copay for certain physician specialist visits including: Cardiologists, Endocrinologists, Nephrologists, and Pulmonologists. $25 copay for all other physician specialist visits.
Inpatient Hospital Stay	$436 per day, days 1-7; $0 per day, days 8-90
Outpatient Hospital	$400
Monthly OTC Allowance	All members receive a **$27 monthly allowance loaded to their Extra Benefits Card (EBC) - OTC Wallet** to help cover approved OTC products. If a member **meets the 3-prong SSBCI eligibility, their OTC Wallet will upgrade to an Extra Supports Wallet (ESW)** to help pay for certain everyday expenses, including healthy foods, OTC products, personal care products, transportation and utilities. **SSBCI qualified members who select a HVP as their PCP will also get a $30 monthly allowance loaded to their EBC – Extra Supports HVP Wallet.**
Annual Dental Allowance	$2,000 - Deluxe EPO Mandatory
Annual Eyewear Allowance	$200 - EyeMed
Annual Hearing Allowance	$1,000 per ear
RX Deductible	$700 (tiers 3-5)
Retail Drug One-Month	T1 $0 | T2 $0 | T3 9% | T4 25% | T5 25%

C-SNP Message Clarity

The Right Member	**C-SNP is designed for people with chronic health needs – not financial status**
The Right Fit	**C-SNP is not a replacement for D-SNP** It is a specialized solution for members with chronic conditions. “We can continue supporting the member because their chronic condition didn’t disappear when Medicaid eligibility changed.”
The Right Support	**The plan is built around the condition – not simply around benefits that show up on paper.** Care model, care management, and member experience are what sets Aetna apart.
The Right Value	**Value = better health support + financial relief** Focusing only on dollars and benefits turns the conversation into a comparison of numbers. Focusing on how the plan supports the member's health creates a stronger value story.

C-SNP qualifications and enrollment

1 Initial enrollment and PQAT collection process

- Member enrolls via paper or electronic application with broker
- **Prequalification Assessment Tool (PQAT) completed as part of the application**
- **The form should be completed in its entirety.** If deficiencies are found (including PQAT), standard request for information process is followed
- If deficiencies are resolved, the enrollment is processed
- If not resolved, enrollment will be denied

2 Verification of chronic condition (VCC)

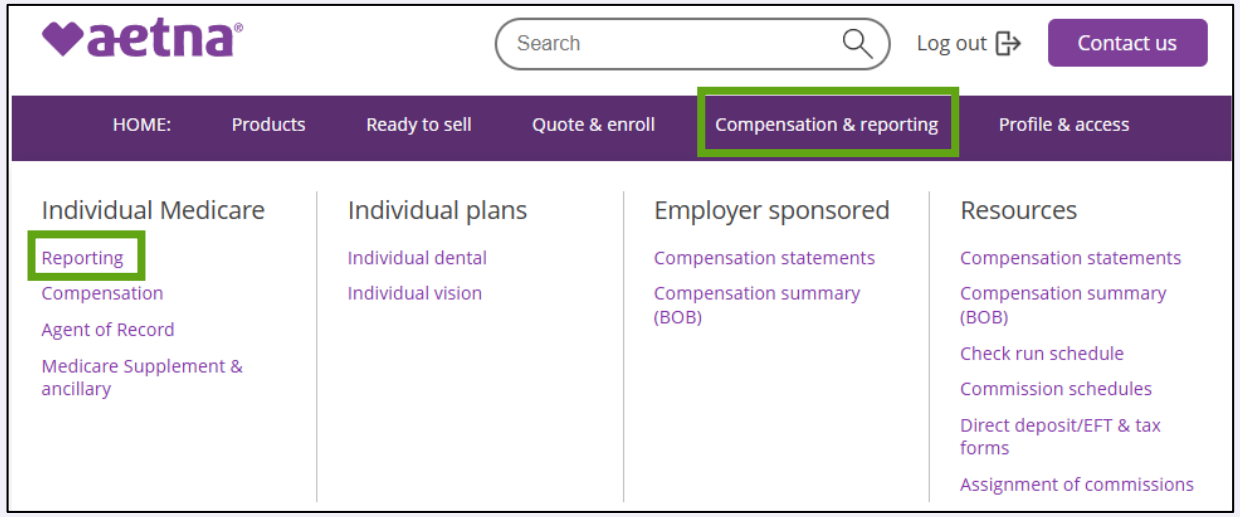
- Aetna captures the health care provider(s) information from PQAT at the time of enrollment
- Aetna connects with the health care provider(s) requesting attestation that member has an eligible chronic condition
- Providers can download the VCC form on Aetna.com, print and return via fax or email

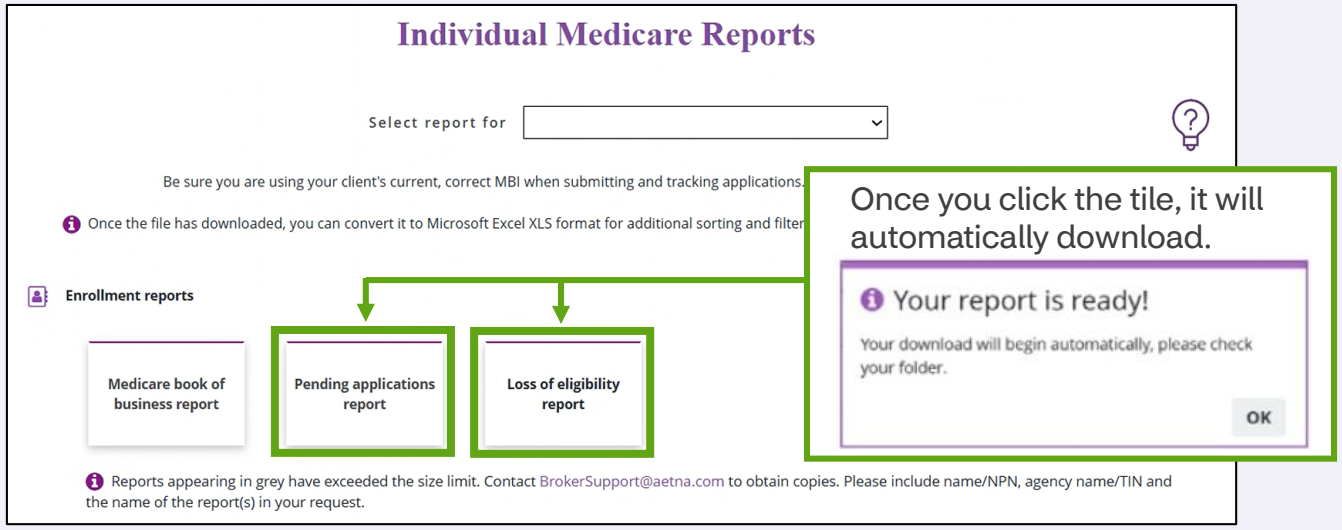
3 Enrollment confirmed or termed

- If health care provider(s) attestation is received by the **end of second month**, member stays enrolled
- If health care provider(s) attestation is not received by the end of second month, member is involuntarily disenrolled

Note: *Involuntarily disenrolled members will then be eligible for a SEP to enroll into another plan.*

Check the status of your applications & member eligibility





Producer World provides real-time visibility into your clients' enrollment status.

Use the **Pending Applications Report & Loss of Eligibility Report** to see status of applications and C-SNP eligibility.

Accessing the Reports:

1. Log in to **Producer World**
2. At the banner on top of the page, click **"Compensation & reporting,"** and then under **"Individual Medicare"** select **"Reporting."**
3. Select the report you want to view.

The **Loss of Eligibility report** will show you if a VCC has not been received and the member is pending termination.

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C-SNP is a year-round selling opportunity

C-SNP sales don't end on December 7.

Being aware of Special Enrollment Periods (SEPs) can help you better serve your clients by offering them tailored coverage for their chronic condition.

C-SNP special election periods

- Members qualify for a new SEP when they have a **qualifying C-SNP chronic condition diagnosis.**
- If a member develops a **new qualifying condition not covered by their current C-SNP**, they receive a new SEP to switch into a C-SNP that supports that condition.
- **Members receive one SEP per new qualifying condition.**
- Once they enroll in a C-SNP for that condition, **the SEP ends**.

If the condition is not verified within the two-month deeming period, the member will be disenrolled from the plan and will receive a 63 day SEP to enroll in a new plan or return to Original Medicare.

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Thank you.


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