2023 Aetna Medicare Advantage Plan Information

Thank you for your interest in applying for the Aetna Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Aetna within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

Star Rating: <u>HMO / PPO</u>
<u>Application Download</u>
<u>Summary of Benefits</u>
<u>Provider Search</u>
<u>Pharmacy Search</u>

Formulary

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC

PO Box 26540 Eugene, Oregon 97402 Fax: 1.541.284.2994 or 888.632.5470

Secure File Upload: <u>Click here</u> Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: http://www.medicare-texas.net

Y0062 MULTIPLAN CDA INSURANCE Texas 2023 (Pending)

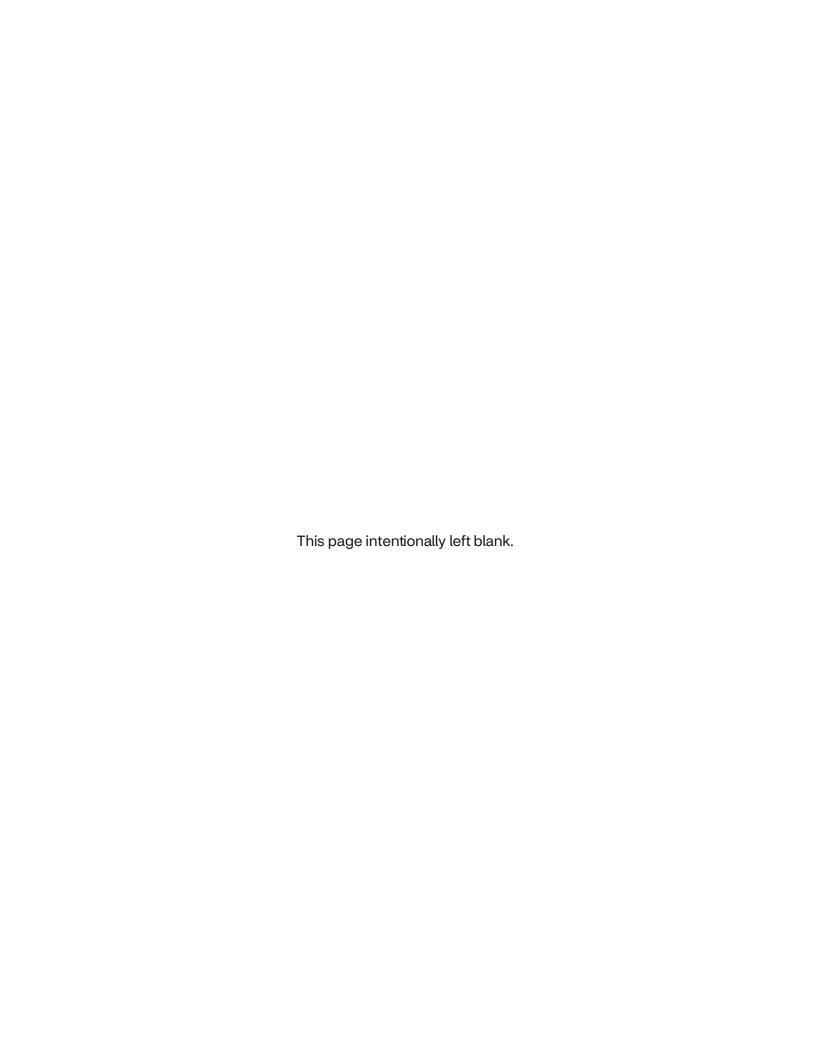


Confirm your enrollment period

Typically, you may enroll in a Medicare Advantage Plan 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.

Read the following statements carefully and check the box if the statement applies to you. By checking a box you certify that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

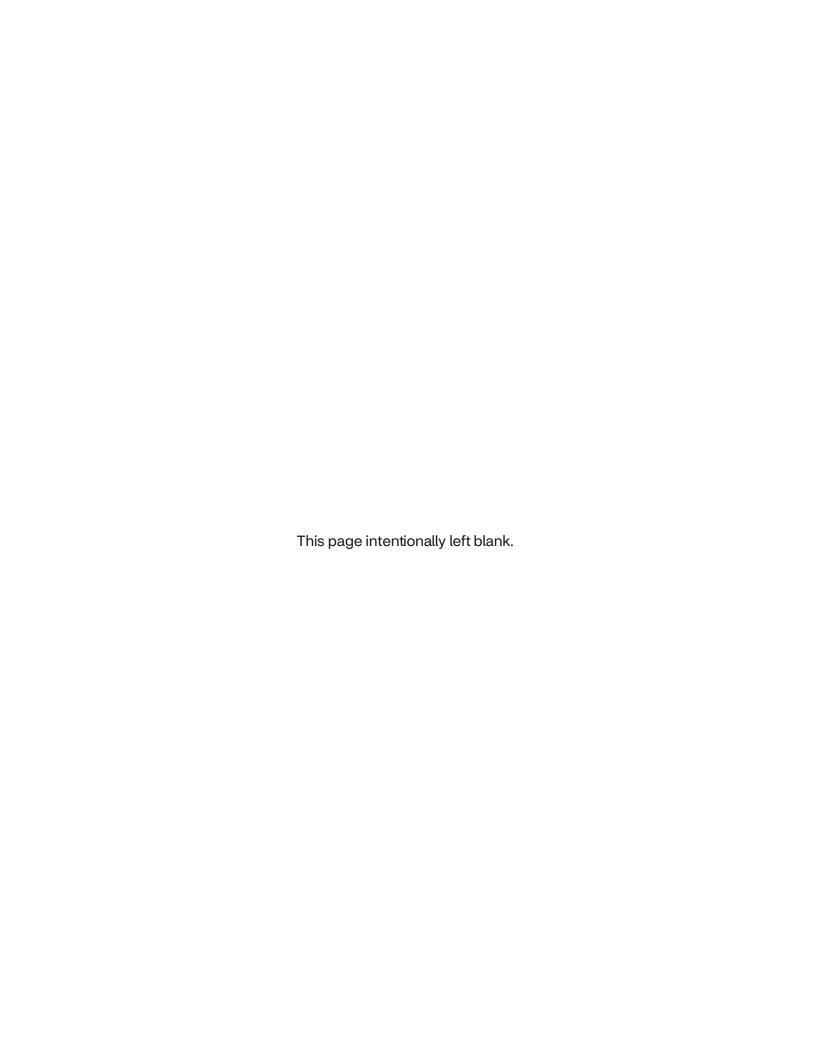
Prospective member name	Medicare Number
Reason for Annual Enrollment Period Eligibility	
☐ I'm enrolling between 10/15/22-12/7/22 during	the current Annual Enrollment Period.
Reasons for Initial Enrollment Period Eligibility	
☐ I'm new to Medicare.	
☐ I'm new to Medicare, and I was notified about coverage started.	getting Medicare after my Part A and/or Part B
☐ I had Medicare prior to now, but I'm now turnin	g 65.
Reasons for Open Enrollment Period Eligibility	
Between 1/1/23 and 3/31/23:	
$\ \square$ I'm in a Medicare Advantage plan and want to	make a change.
Between 4/1/23 and 12/31/23:	
☐ I'm in a Medicare Advantage plan and have had change.	d Medicare for less than 3 months. I want to make a
Reasons for Special Enrollment Period Eligibilit	у
☐ I moved to a new address that's outside my cur plan is a new option for me. I moved on/_	rrent plan's service area, or I recently moved and this/ (date).
□ I was released from jail. I was released on	// (date).
☐ I moved back to the United States after living o/ (date).	utside the country. I returned to the U.S. on
$\hfill\Box$ I recently got lawful presence status in the Unit	red States. I got this status on// (date).
☐ I recently had a change in my Medicaid (newly assistance, or lost Medicaid) on///	· ·
☐ I recently had a change in my Extra Help paying change in the level of Extra Help, or lost Extra H	
	(continued on next page)







Prospective member name	Medicare Number	
Reasons for Special Enrollment Period Eligibility (continu	ued)	
☐ I have both Medicare and Medicaid, my state helps pay Help paying my Medicare drug coverage.	for my Medicare premiums, or I get Extra	
☐ I dropped my coverage in a PACE (Programs of All-Inclu //_ (date).	sive Care for the Elderly) plan on	
$\hfill \square$ I live in a long-term care facility, like a nursing home or a	a rehabilitation hospital.	
☐ I recently moved out of a long-term care facility, like a nemoved out of the facility on/ (date).	ursing home or rehabilitation hospital. I	
☐ I lost other, non-Medicare drug coverage (creditable coverage and is no longer considered creditable coverage// (date).		
$\hfill \square$ I left coverage from my employer or union (including CC	DBRA coverage) on// (date).	
☐ I'm in a State Pharmaceutical Assistance Program, or I a Assistance Program.	am losing help from a State Pharmaceutical	
☐ I lost my coverage because my plan no longer covers th Medicare.	e area that I live or it ended its contract with	
☐ I was enrolled in a plan by Medicare (or my state) and I vertex enrollment in that plan started on/ (date).	· · · · · · · · · · · · · · · · · · ·	
☐ I lost my Special Needs Plan because I no longer have a disenrolled from the plan on// (date).	condition required for that plan. I was	
☐ I was affected by an emergency or major disaster (as de Management Agency, or by Federal, my state or my loca applied to me, but I was unable to make my request bed	al government). One of the other statements	
If none of these statements above apply to you, but you fee allows you to enroll, you can call us at 1-833-859-6031 (TT days a week, from October 1 to March 31 and 8 AM to 8 PM September 30. We can help you to determine if you qualify	'Y: 711) . We're here 8 AM to 8 PM, seven 1, Monday through Friday, from April 1 to	
Otherwise, note the reason for your Special Election period if you're eligible.	d below. Aetna may contact you to determine	
□ Other SEP Reason:		

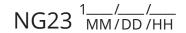




Enrollment Request Form

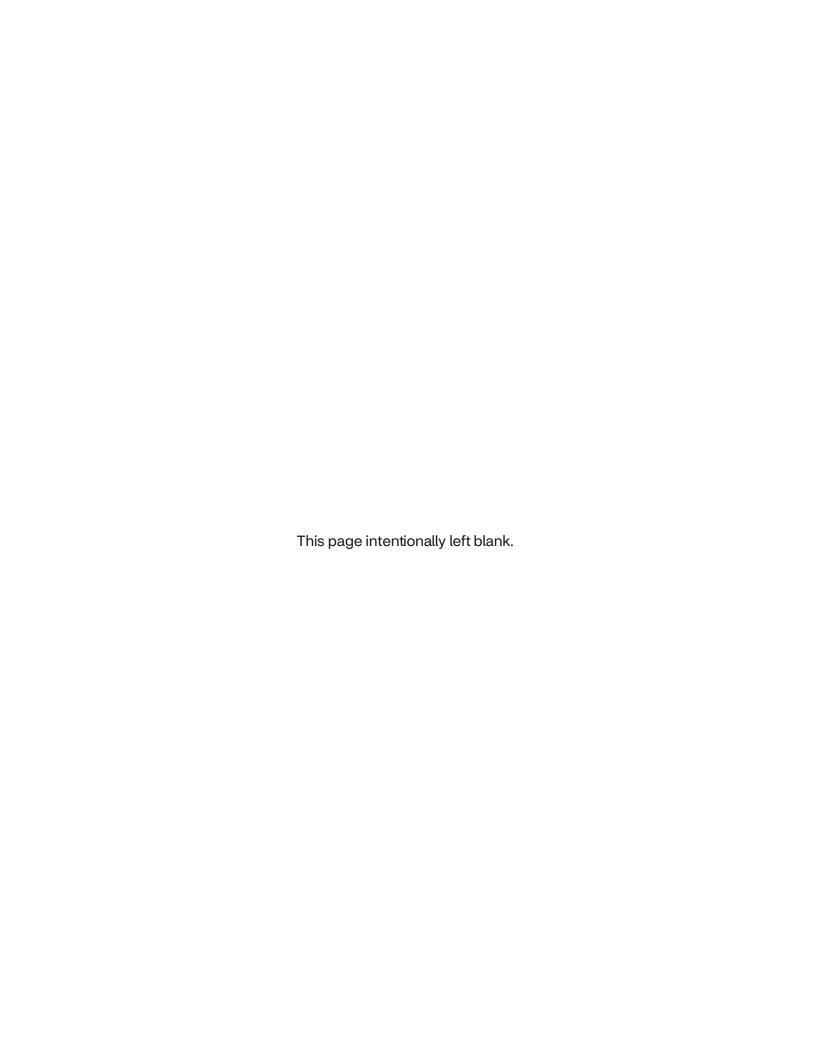
Agent Use Only:
Agent Name:
NPN#:

To enroll in an Aetna plan, please provide	the following information:	
Choose your plan		
Check the plan you want to enroll in.		
☐ Aetna Medicare Choice Plan (PPO) (H3288-005)	\$0.00 p	er mont
Note: Plans with an asterisk (*) next to the plan nam See the Choose your Primary Care Provider (PCP)	· · · · · · · · · · · · · · · · · · ·	assigned
Proposed Effective Date of Coverage:// Effective dates are based on the enrollment period y & Medicaid Services' regulations. Unless you are ne Period (SEP), your effective date will be January 1. A requested will be honored.	you're using to enroll and the Centers for Me w to Medicare or are eligible for a Special Ele	ection
Choose your Primary Care Prosome of our plans coordinate your care through a R (*) next to the plan name (Example: "*Aetna Prime asterisk, and do not choose a PCP, we may not pay note that a specialist is not considered a valid PC	PCP. We have noted these plans with an aste Plan (HMO)"). If you selected a plan noted w for your care and will assign a PCP to you. P	ith an
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.		e the
Write in the name , Provider ID and Primary Care I our online provider directory at AetnaMedicare.co to find provider information or a network PCP for you	om/findprovider or call 1-833-859-6031 (TT	
Full name of your PCP (first and last name)	Are you a current patient?	
	□ Yes □ No	



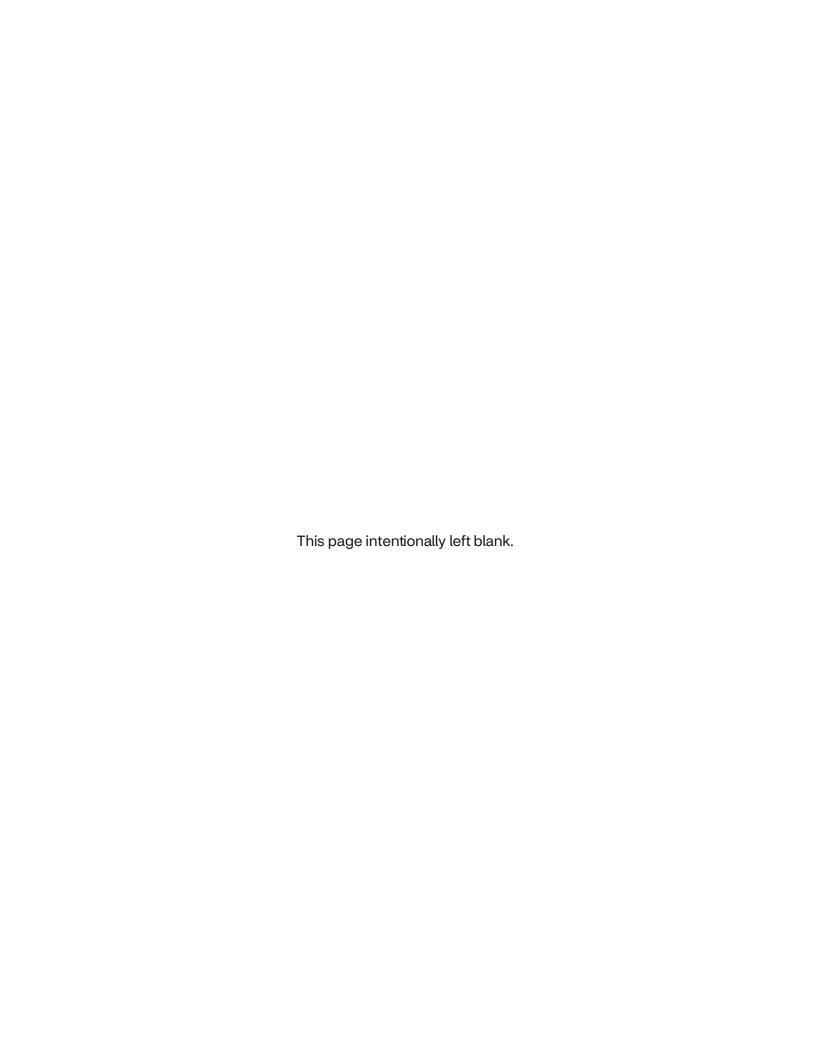
Provider ID (located in the provider directory)

Primary Care ID (located in the provider directory)



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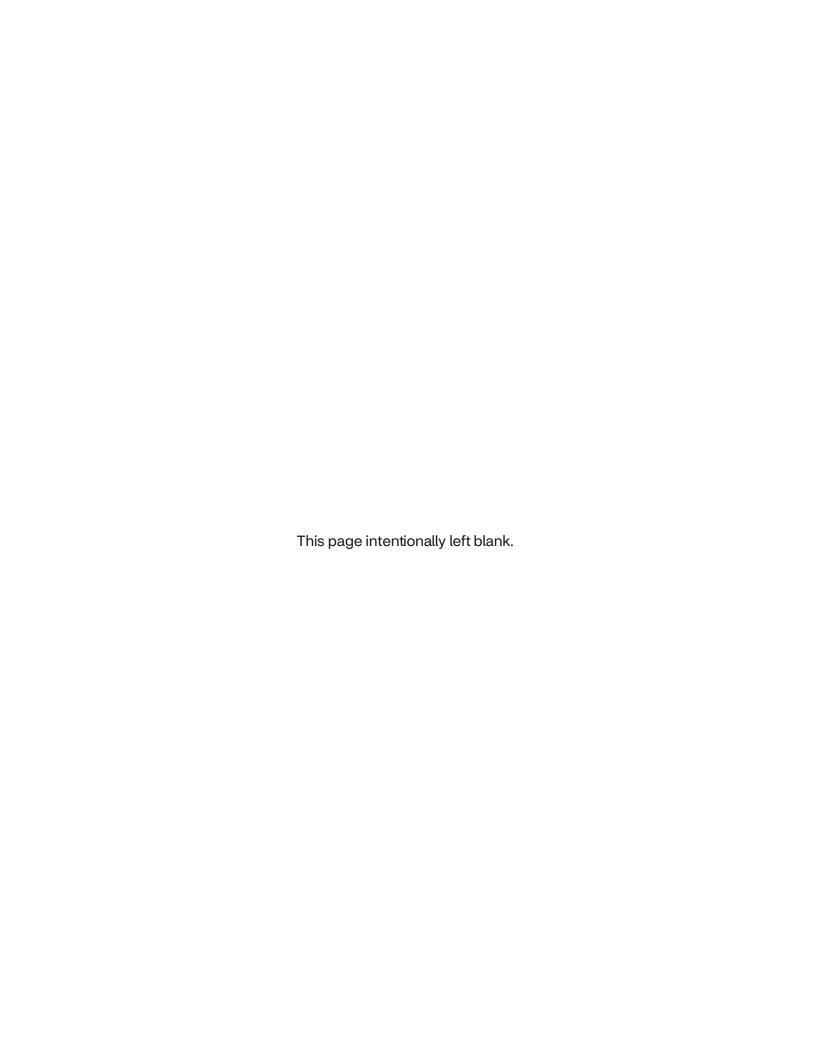
Last name		First Name		Middle initial
Birth date		Sex	Phone number: ()	
$\frac{1}{M} \frac{1}{M} \frac{1}{D}$	$\frac{1}{D}$ $\frac{1}{A}$ $\frac{1}{A}$ $\frac{1}{A}$ $\frac{1}{A}$ $\frac{1}{A}$	□ M □ F	Is this a mobile number? 🗆 Ye	es □ No
Email addres	SS			
Permanent r	esidence street address	- including A	pt/Suite/Unit (a PO Box is not al	lowed)
City		County	State	ZIP code
Mailing addr	ess - including Apt/Suite	e/Unit (if diffe	rent from your permanent street	address)
		City	State	ZIP code
		Part A and Par	and blue Medicare insurance cat B to join a Medicare Advantage Effective HOSPITAL (Part A)/	plan. Date:
			MEDICAL (Part B)/	_/
Answer the	ese important questio	ons		
□ Yes □ No	1. Will you have other <u>prescription</u> 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 coveraç	ge: 		
☐ Yes ☐ No	2. Are you enrolled in If "Yes," write in your Me	-		



Please tell us a little more about yourself

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.				
$\ \square$ No, not of Hispanic, Latino/a, or Spanish o		☐ Yes, Mexican, Mexican American, Chicano/a		n, Mexican American, Chicano/a
☐ Yes, Puerto Rican		□ Yes, Cuban		
☐ Yes, another Hispanic, Latino/a, or	Spanish origin			
$\ \square$ I choose not to answer.				
What's your race? Select all that apply	y .			
☐ American Indian or Alaska Native	□ Asian India	n		Black or African American
□ Chinese	□ Filipino			Guamanian or Chamorro
□ Japanese	□ Korean			Native Hawaiian
□ Other Asian	□ Other Pacif	ic Islander		Samoan
□ Vietnamese	□ White			
□ I choose not to answer.				
Indicate your preferred spoken language (if not English):				
☐ Spanish ☐ Other (please specify):				
Indicate your preferred written language (if not English):				
☐ Spanish ☐ Other (please specify):				
If you need information in another language or accessible format (for example, large print or braille), contact us at 1-833-859-6031 (TTY: 711) , 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM. Monday through Friday, from April 1 to September 30.				



Plan premium and/or late enrollment penalty (LEP) payment

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

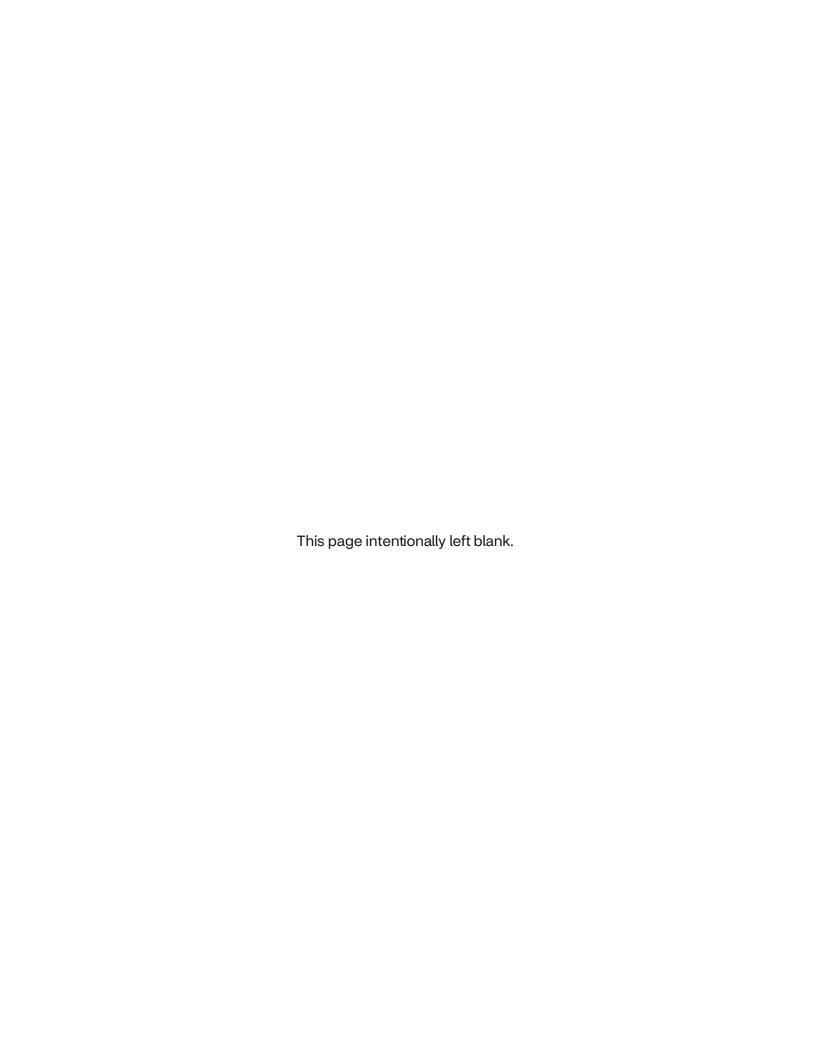
- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past 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:
Sig	DUTING NUMBER ACCOUNT NUMBER Account type: Checking Checking Savings Gnature of account holder: (if different than enrollee) Gree that this authorization will remain in effect until I provide written notification terminating this revice.
	Automatic deduction from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) 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 (DSNP) or an Institutional Special Needs Plan (ISNP).
- SSA or RRB will tell us when your premium deduction will start coming out of your SSA/RRB check. You'll need to pay your premiums directly to us for any months the SSA/RRB doesn't cover. We'll send you an invoice for the months SSA/RRB doesn't cover.
- Sometimes SSA/RRB may not accept the request for deductions from your SSA/RRB check. If they don't accept the deduction request, 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 retail CVS Pharmacy and pay with cash, credit card, or debit card. (This service is not available at CVS Pharmacy Target® or Schnucks Pharmacy locations.) (continued)



Plan premium and/or late enrollment penalty (LEP) payment 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 www.socialsecurity.gov/prescriptionhelp.
- 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.

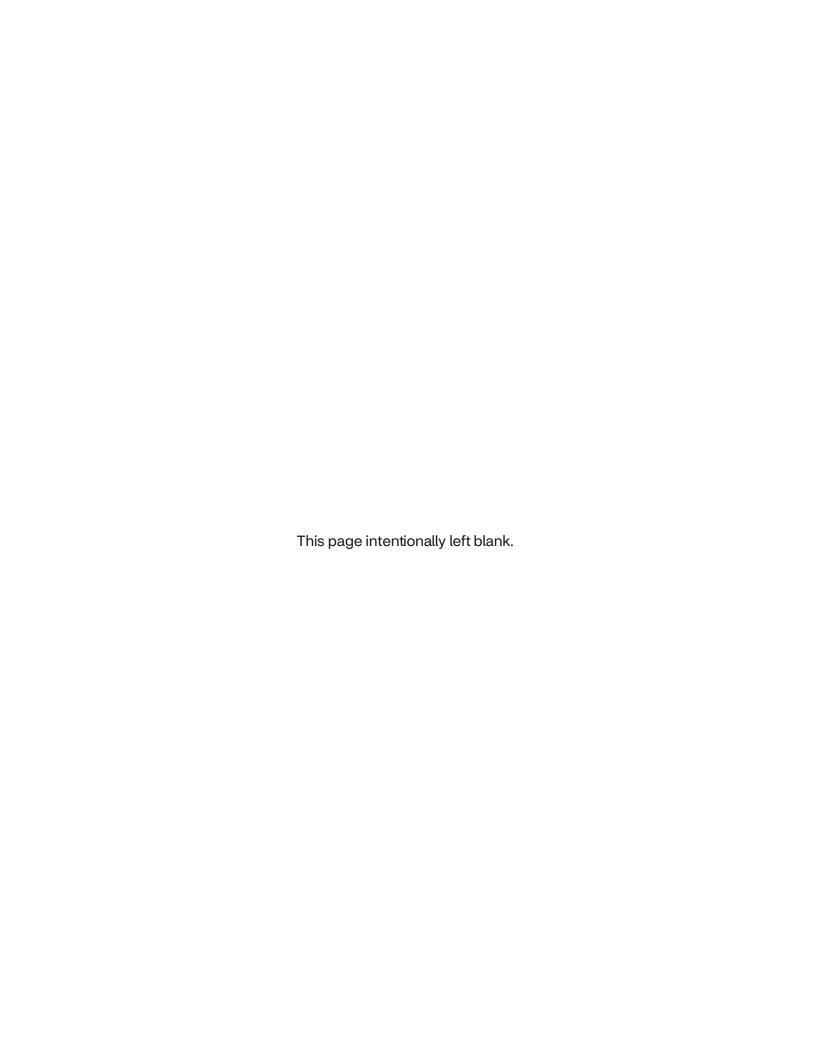
Read this important information and sign below

- 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 below).

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).
- 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

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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.

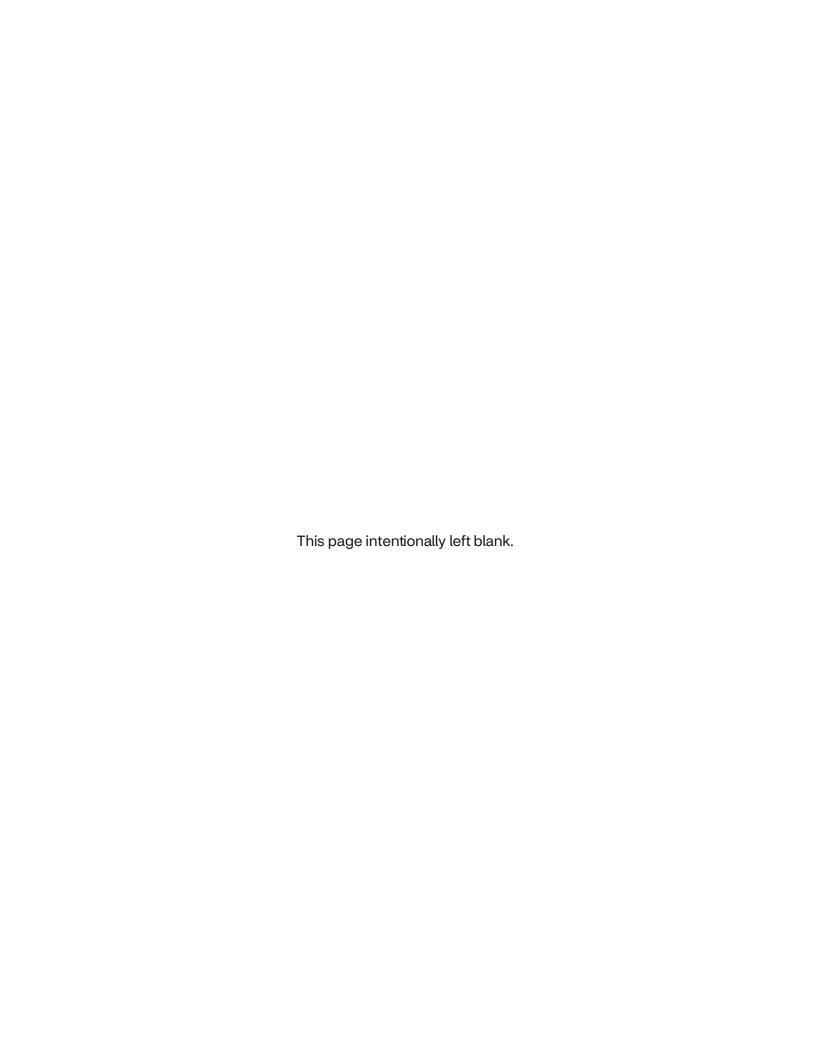
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I
 intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf 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 DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

Signature		Today's date
If you're an authorized representative helping someone fill out this form, you must sign above and provide the following information.		ou must sign above and
Name	Address	
Phone number (Relationship to enrollee	

According to the Paperwork Reduction Act (PRA) of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "How to Enroll" on the first page of this form to send your completed form to the plan.



AGENT USE ONLY

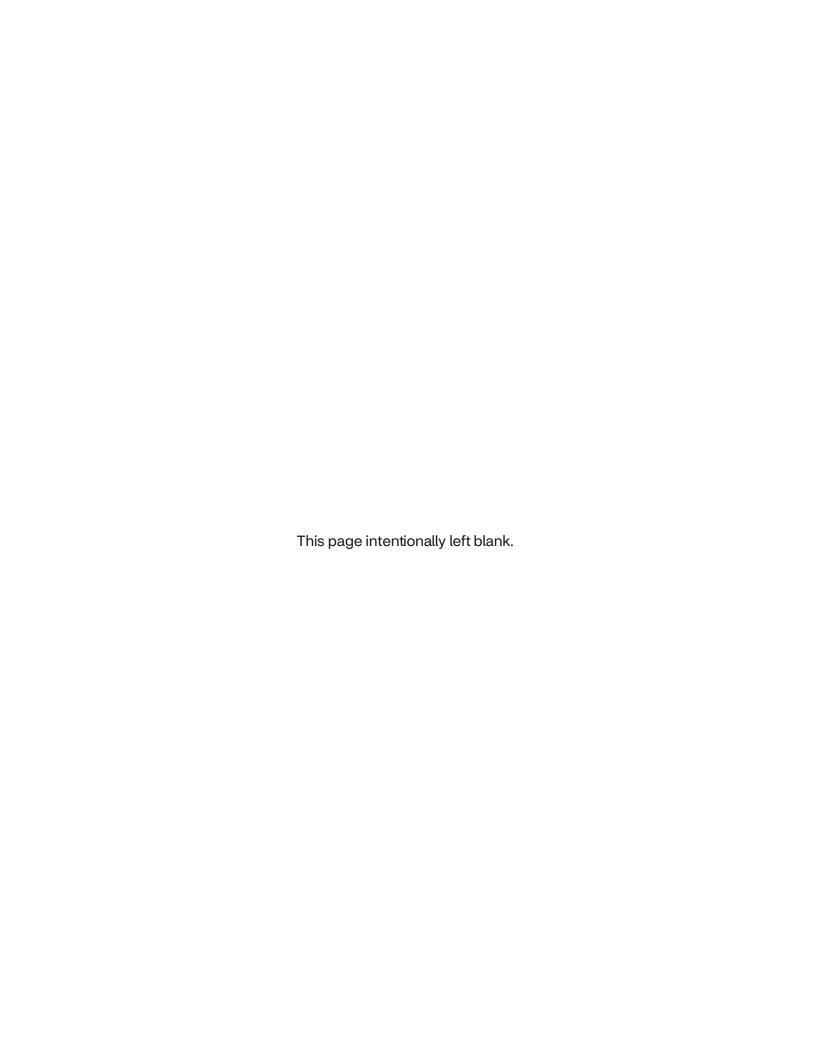
Agent/producer/broker/representative must complete this section

Applicant's name			
_	agent/producer/broker/emplo ormation and submit it with the o	yed sales representative, you must provide the completed application.	
□ Yes □ No		SOA) completed? (The SOA must be agreed to by the personal individual marketing appointment.)	
□ Yes □ No	Was the SOA captured electronically or by telephone? If "Yes," please provide the confirmation/ID number: Attach the SOA or indicate why it's not available:		
Name of agent/producer/broker/sales rep:			
Phone number	Phone number: National Producer Number (NPN):		
□ Check box if application received at a retail kiosk.			
NOTE: If the agent/producer/broker/employed sales representative takes receipt of this application, a signature and date are <u>REQUIRED</u> 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 7405 London, KY 40742 Fax: 1-866-756-5514





Medicare Advantage Plan Enrollment Receipt

Agent/Broker: Complete and leave with enrollee.

Keep this as proof of your enrollment request until Medicare has confirmed your enrollment and you receive your member materials. This receipt is not a guarantee of enrollment.

This receipt is for your records only. No further action is necessary.

Applicant		
Name:		
Today's Date:	Proposed Effective Date:	
Call your Agent/Broker if you have any questions		
Agent/Broker Name:		
Agent/Broker Phone Number:	Agent/Broker ID:	

If you would like a complete copy of your enrollment form, call us at **1-800-562-6315 (TTY: 711)**, 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30. Please allow at least 3 business days for us to process your application. **You'll need to provide your application tracking number, located at the bottom of this page.**

Reminder - Your enrollment request is for a Medicare Advantage plan (Part C). These plans:

- Replace Original Medicare that's provided by the federal government
- Cover all your Part A and Part B benefits
- Don't supplement your Original Medicare coverage like Medicare Supplement or Medigap plans

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Our DSNPs also have contracts with State Medicaid programs. Plan features and availability may vary by service area.