aetna® Medicare Solutions

Plan Summary Worksheet

Use this form to outline key elements of the plan you selected. You can fill it out with your licensed agent and keep a copy for your records.

Today's date:	Your name:

About your new plan

My new plan is a (check one):

☐ Medicare Advantage plan with drug coverage (MAPD) (replaces your Medicare Part A, Part B, provides Part D)

☐ Medicare Advantage plan without drug coverage (MA) (replaces your Medicare Part A, Part B only)

☐ Medicare Prescription Drug Plan (PDP)

My new plan is NOT a Medicare Supplement plan (covers some of the costs that Original Medicare doesn't cover).

The name of my new plan is:

My plan (check those that apply):

☐ Requires referrals ☐ Requires me to use network doctors

☐ Does NOT require referrals ☐ Allows me to see doctors out of network, usually at a higher cost

My requested plan effective date is:

You can cancel your enrollment before your plan coverage starts. Just call us at **1-800-282-5366 (TTY: 711)** or call your agent for assistance. Once your coverage starts, you may have to wait until the annual enrollment period to make a plan change, unless you qualify for a special election period.

Plan premium and benefit information

My plan has a $_____ monthly premium.

The amount above does not include any Late Enrollment Penalty. Those with Extra Help may pay less than this amount.

Benefit summary information (for MA/MAPD plans only)

Fill in the items that apply for your plan:

	In network	**Out of network**
Medical deductible		
PCP copay		

Dental Coverage (check those that apply):

☐ Not available

☐ Requires you to use a network dentist

☐ Reimbursement benefit (you pay upfront and submit a receipt for reimbursement)

☐ Only available if you enroll in the plan's supplemental dental coverage (for an additional premium)

- ☐ You signed up for dental coverage. It has an additional premium of $_____
- ☐ You chose NOT to enroll in dental coverage

Network information

As a reminder, your plan has a network of providers. Be sure you and your agent confirmed network participation for the doctors you want to see. To see if a doctor, hospital or pharmacy is in your plan's network, visit us at **www.aetnamedicare.com/helpfultools**.

Provider name	**In-network?**	**Do you need a referral to see this provider?**
	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Prescription drug coverage (for plans with prescription drug coverage)

Complete this chart with your agent. Remember to use our online tools, like **www.aetnamedicare.com/helpfultools** for the most accurate information.

My plan has a deductible for drugs on: ☐ Tiers 3-5 ☐ Tiers 4-5

Medication and dosage	**Drug tier**	**Are there any limitations? If so, what type?** (QL, PA, ST)	QL = quantity limits PA = prior authorization ST = step therapy

Remember, your actual out-of-pocket costs may vary based on the drug coverage stage you're in (deductible stage, initial coverage stage, coverage gap or catastrophic coverage), the drug tier level and the pharmacy you use (standard, preferred or mail order). You can also contact Social Security at **1-800-772-1213** to see if you qualify for Extra Help.

Pharmacy information

The name of my pharmacy is:	This pharmacy is: ☐ **Preferred** ☐ **Standard**

Questions? Call your licensed agent

Agent name:	Contact phone number:

Thanks for your time today! Keep this worksheet for your records.
What happens next?

- If we need more information to process your enrollment, we'll reach out to you. Please be sure to respond to requests timely to avoid any issues.
- We'll let you know once you've been accepted into our plan.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. This information is not a complete description of benefits. Call 1-800-282-5366 (TTY: 711) for more information. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.