

2026 Plan Guide

Aetna Medicare Elite (PPO) H5521-120
Aetna Medicare Elite Extra (PPO) H5521-674
Aetna Medicare Enhanced (HMO) H3312-064
Aetna Medicare Enhanced (PPO) H5521-665
Aetna Medicare Eagle Giveback (PPO) H5521-320

What you'll find inside

- Service areas
- In-network benefits for selected services
- In-network costs for selected services
- Additional benefits
- Prescription drugs

When joining a plan

Review the following pages for in-network costs for some of our Medicare benefits. It's not a complete list. For more information, refer to the *Summary of Benefits or Evidence of Coverage*, visit our website [AetnaMedicare.com](https://www.aetna.com) or call us at [1-833-859-6031](tel:1-833-859-6031) (TTY: [711](tel:711)). Your call may be answered by a licensed agent.

Service area

Plan name	Contract PBP	Plan service area
Aetna Medicare Elite (PPO)	H5521-120	New York: Bronx, Kings, Nassau, Queens, Rockland, Suffolk, Westchester
Aetna Medicare Elite Extra (PPO)	H5521-674	New York: Nassau, Suffolk
Aetna Medicare Enhanced (HMO)	H3312-064	New York: Nassau, Suffolk
Aetna Medicare Enhanced (PPO)	H5521-665	New York: Nassau, Suffolk
Aetna Medicare Eagle Giveback (PPO)	H5521-320	New York: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester

Medical and hospital benefits

Benefits listed are for services received in-network and per visit unless otherwise stated.

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
Monthly plan premium	\$0	\$54
Part B premium reduction	\$0	\$0
Plan deductible	\$1,000* for certain in-network and out-of-network services combined.	\$1,500* for certain in-network and out-of-network services combined.
Annual maximum out-of-pocket amount (does not include premium or prescription drug costs)	\$9,250 for in-network services. \$13,900 for in- and out-of-network services combined.	\$9,250 for in-network services. \$13,900 for in- and out-of-network services combined.
Hospital coverage		
Inpatient hospital care	\$399 per day, days 1-6; \$0 per day, days 7-90 after plan deductible; \$0 for additional days. Our plan covers unlimited hospital days.	\$399 per day, days 1-6; \$0 per day, days 7-90 after plan deductible; \$0 for additional days. Our plan covers unlimited hospital days.
Outpatient hospital	\$45 - \$399 copay after plan deductible \$45 copay for outpatient hospital services other than surgery \$399 copay for each outpatient hospital surgery	\$45 - \$395 copay after plan deductible \$45 copay for outpatient hospital services other than surgery \$395 copay for each outpatient hospital surgery
Ambulatory surgery center (ASC)	\$350 copay after plan deductible is met	\$350 copay after plan deductible is met
Skilled nursing facility	\$0 per day, days 1-20; \$218 per day, days 21-100 after plan deductible Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$218 per day, days 21-100 after plan deductible Our plan covers up to 100 days per benefit period.
Doctor visits		
Annual routine physical	\$0 copay for an annual routine physical exam.	\$0 copay for an annual routine physical exam.
Primary care provider (PCP)	\$5 copay	\$0 copay

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
\$94	\$134	\$0
\$0	\$0	\$75
\$0	\$0	\$0
\$9,250	\$6,750 for in-network services. \$10,100 for in- and out-of-network services combined.	\$9,250 for in-network services. \$13,900 for in- and out-of-network services combined.
\$395 per day, days 1-6; \$0 per day, days 7-90; \$0 for additional days. Our plan covers unlimited hospital days.	\$399 per day, days 1-6; \$0 per day, days 7-90; \$0 for additional days. Our plan covers unlimited hospital days.	\$395 per day, days 1-6; \$0 per day, days 7-90; \$0 for additional days. Our plan covers unlimited hospital days.
\$45 - \$395 copay \$45 copay for outpatient hospital services other than surgery \$395 copay for each outpatient hospital surgery	\$45 - \$399 copay \$45 copay for outpatient hospital services other than surgery \$399 copay for each outpatient hospital surgery	\$35 - \$500 copay \$35 copay for outpatient hospital services other than surgery \$500 copay for each outpatient hospital surgery
\$325 copay	\$350 copay	\$300 copay
\$0 per day, days 1-20; \$218 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$218 per day, days 21-100 Our plan covers up to 100 days per benefit period.	\$0 per day, days 1-20; \$218 per day, days 21-100 Our plan covers up to 100 days per benefit period.
\$0 copay for an annual routine physical exam.	\$0 copay for an annual routine physical exam.	\$0 copay for an annual routine physical exam.
\$0 copay	\$0 copay	\$0 copay

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
PCP referrals	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.
Specialist	\$45 copay	\$45 copay
Emergency and urgent care		
Emergency care	\$115 copay	\$115 copay
Urgently needed services	\$40 copay	\$40 copay
Worldwide coverage (i.e., outside of the United States)	\$115 copay for emergency and urgent services worldwide. \$250,000 maximum coverage.	\$115 copay for emergency and urgent services worldwide. \$250,000 maximum coverage.
Diagnostic testing		
X-rays and diagnostic radiology (e.g., CT scan, MRI)	X-rays: \$45 copay Diagnostic radiology: \$225 - \$300 copay Lower cost sharing is for CT/CAT scans.	X-rays: \$45 copay Diagnostic radiology: \$225 - \$300 copay Lower cost sharing is for CT/CAT scans.
Lab services	\$10 copay You'll pay \$0 copay for certain lab services.	\$0 copay
Dental, vision and hearing (non-Medicare covered)		
Dental services	\$0 for preventive services. Comprehensive services are covered under optional supplemental benefits. Aetna Dental PPO Network	Our plan pays \$1,000 every year for in- and out-of-network preventive and comprehensive dental services combined. Aetna Dental PPO Network
Routine eye exam	\$0 copay with an EyeMed provider (one exam every year)	\$0 copay with an EyeMed provider (one exam every year)
Contacts and eyeglasses	Our plan pays \$100 every year for prescription eyewear. EyeMed Network	Our plan pays \$100 every year for prescription eyewear. EyeMed Network
Routine hearing exam	\$0 copay (one exam every year) Appointments should be scheduled through NationsHearing®.	\$0 copay (one exam every year) Appointments should be scheduled through NationsHearing®.

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.	This plan doesn't require a referral to see a specialist.
\$45 copay	\$45 copay	\$35 copay
\$115 copay	\$130 copay	\$115 copay
\$40 copay	\$50 copay	\$40 copay
\$115 copay for emergency and urgent services worldwide.	\$130 copay for emergency and urgent services worldwide.	\$115 copay for emergency and urgent services worldwide.
\$250,000 maximum coverage.	\$250,000 maximum coverage.	\$250,000 maximum coverage.
X-rays: \$45 copay	X-rays: \$45 copay	X-rays: \$35 copay
Diagnostic radiology: \$225 - \$300 copay Lower cost sharing is for CT/CAT scans.	Diagnostic radiology: \$225 - \$325 copay Lower cost sharing is for CT/CAT scans.	Diagnostic radiology: \$275 - \$325 copay Lower cost sharing is for CT/CAT scans.
\$5 copay You'll pay \$0 copay for certain lab services.	\$10 copay You'll pay \$0 copay for certain lab services.	\$0 copay
\$0 for preventive services. Comprehensive services are covered under optional supplemental benefits.	\$0 for preventive services. Comprehensive services are covered under optional supplemental benefits.	Our plan pays \$1,500 every year for in- and out-of-network preventive and comprehensive dental services combined.
You must use the Aetna Dental PPO Network.	Aetna Dental PPO Network	Aetna Dental PPO Network
\$0 copay with an EyeMed provider (one exam every year)	\$0 copay with an EyeMed provider (one exam every year)	\$0 copay with an EyeMed provider (one exam every year)
Our plan pays \$150 every year for prescription eyewear.	Our plan pays \$100 every year for prescription eyewear.	Our plan pays \$200 every year for prescription eyewear.
You must use the EyeMed network.	EyeMed Network	EyeMed Network
\$0 copay (one exam every year)	\$0 copay (one exam every year)	\$0 copay (one exam every year)
Appointments must be scheduled through NationsHearing®.	Appointments should be scheduled through NationsHearing®.	Appointments should be scheduled through NationsHearing®.

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
Hearing aids	Every year, you have a \$0 - \$1,700 copay. (Copay may vary based on technology; see <i>Summary of Benefits</i> for more details.) Hearing aids must be purchased through NationsHearing®.	Every year, you have a \$0 - \$1,700 copay. (Copay may vary based on technology; see <i>Summary of Benefits</i> for more details.) Hearing aids must be purchased through NationsHearing®.
Therapy		
Physical and speech therapy	\$35 copay	\$35 copay
Occupational therapy	\$35 copay	\$30 copay
Outpatient mental health therapy (individual)	\$40 copay	\$45 copay
Ambulance		
Ground ambulance (one-way trip)	\$285 copay	\$290 copay
Air ambulance (one-way trip)	\$285 copay	\$290 copay
Equipment		
Durable medical equipment	0% - 20% coinsurance Lower cost sharing is for continuous glucose monitors.	0% - 19% coinsurance Lower cost sharing is for continuous glucose monitors.
Additional benefits		
24-Hour Nurse Line	\$0 copay Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.****	\$0 copay Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.****

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
Every year, you have a \$0 - \$1,700 copay. (Copay may vary based on technology; see <i>Summary of Benefits</i> for more details.)	Every year, you have a \$0 - \$1,700 copay. (Copay may vary based on technology; see <i>Summary of Benefits</i> for more details.)	Every year, you have a \$0 - \$1,700 copay. (Copay may vary based on technology; see <i>Summary of Benefits</i> for more details.)
Hearing aids must be purchased through NationsHearing®.	Hearing aids must be purchased through NationsHearing®.	Hearing aids must be purchased through NationsHearing®.
\$35 copay	\$40 copay	\$40 copay
\$35 copay	\$40 copay	\$35 copay
\$45 copay	\$45 copay	\$35 copay
\$280 copay	\$280 copay	\$285 copay
\$280 copay	\$280 copay	\$285 copay
0% - 20% coinsurance Lower cost sharing is for continuous glucose monitors.	0% - 20% coinsurance Lower cost sharing is for continuous glucose monitors.	0% - 20% coinsurance Lower cost sharing is for continuous glucose monitors.
\$0 copay Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.****	\$0 copay Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.****	\$0 copay Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.****

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
Special supplemental benefits	Members with certain chronic conditions may be eligible for: Aetna Chronic Care Support Program Members with certain kidney conditions may be eligible for: Aetna Kidney Care Support Program Members with a cancer diagnosis may be eligible for: Aetna Cancer Care Support Program • \$0 copay for certain primary care provider (PCP) services	Members with certain chronic conditions may be eligible for: Aetna Chronic Care Support Program Members with certain kidney conditions may be eligible for: Aetna Kidney Care Support Program Members with a cancer diagnosis may be eligible for: Aetna Cancer Care Support Program
Fitness	Physical fitness program: Basic SilverSneakers® membership.	Physical fitness program: Basic SilverSneakers® membership.
Foot care (additional)	Not covered	Not covered
Meals	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility.
Over-the-counter (OTC) items	Not covered	Not covered
Visitor/travel benefit	Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to 12 months when outside the service area.	Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to 12 months when outside the service area.

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
Members with certain chronic conditions may be eligible for: Aetna Chronic Care Support Program	Members with certain chronic conditions may be eligible for: Aetna Chronic Care Support Program	Members with certain chronic conditions may be eligible for: Aetna Chronic Care Support Program
Members with certain kidney conditions may be eligible for: Aetna Kidney Care Support Program	Members with certain kidney conditions may be eligible for: Aetna Kidney Care Support Program	Members with certain kidney conditions may be eligible for: Aetna Kidney Care Support Program
Members with a cancer diagnosis may be eligible for: Aetna Cancer Care Support Program	Members with a cancer diagnosis may be eligible for: Aetna Cancer Care Support Program	Members with a cancer diagnosis may be eligible for: Aetna Cancer Care Support Program
Physical fitness program: Basic SilverSneakers® membership.	Physical fitness program: Basic SilverSneakers® membership.	Physical fitness program: Basic SilverSneakers® membership.
Not covered	Not covered	\$35 copay (up to six visits every year)
Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility.	Up to 14 home-delivered meals over a 7-day period after being discharged from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility.
Not covered	Not covered	Over-the-counter (OTC) items \$60 benefit amount (allowance) each quarter to purchase approved over-the-counter (OTC) health and wellness items like first aid supplies, external pain relievers, adult care products, and more. The benefit amount is not connected to a payment card or debit card.
Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to 12 months when outside the service area.	Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to 12 months when outside the service area.	Allows you to receive care at in-network cost shares from our participating multi-state provider network for up to 12 months when outside the service area.

Optional supplemental benefits

Extra benefits you can purchase

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
Option 1 (Beyond Original Medicare coverage)	\$38 monthly premium Deluxe Comprehensive Dental Package	Not offered with this plan
Optional Supplemental Benefits Description(s)	20% - 50% cost share Our plan pays \$1,500 every year for comprehensive dental services. Aetna Dental PPO Network	Not offered with this plan

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
\$34 monthly premium Deluxe Comprehensive Dental Package	\$38 monthly premium Deluxe Comprehensive Dental Package	Not offered with this plan
20% - 50% cost share Our plan pays \$1,500 every year for comprehensive dental services. Dental services must be performed by Aetna Dental PPO Network.	20% - 50% cost share Our plan pays \$1,500 every year for comprehensive dental services. Aetna Dental PPO Network	Not offered with this plan

Prescription drugs

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
Rx formulary	B2	B2
Rx deductible	\$615 Does not apply to Tier 1, Tier 2 drugs.	\$615 Does not apply to Tier 1, Tier 2 drugs.
Tier 1 drugs:	Preferred / Standard	Preferred / Standard
• Retail: 30-day supply	\$0 / \$2	\$0 / \$2
• Retail/Mail-order: 100-day supply	\$0 / \$6	\$0 / \$6
Tier 2 drugs:	Preferred / Standard	Preferred / Standard
• Retail: 30-day supply	\$0 / \$12	\$0 / \$12
• Retail: 100-day supply	\$0 / \$36	\$0 / \$36
• Mail-order: 100-day supply	\$0 / \$36	\$0 / \$36
Tier 3 drugs:	Preferred / Standard	Preferred / Standard
• Retail: 30-day supply	24% / 24%	24% / 24%
• Retail/Mail-order: 100-day supply	24% / 24%	24% / 24%
Tier 4 drugs:	Preferred / Standard	Preferred / Standard
• Retail: 30-day supply	25% / 25%	25% / 25%
• Retail/Mail-order: 100-day supply	25% / 25%	25% / 25%
Tier 5 drugs:	Preferred / Standard	Preferred / Standard
• Retail: 30-day supply	25% / 25%	25% / 25%
• Retail/Mail-order: 100-day supply	N/A	N/A
Out-of-pocket threshold	\$2,100	\$2,100

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
B2	B2	No prescription drug benefit coverage is available for this plan.
\$615 Does not apply to Tier 1, Tier 2 drugs.	\$615 Does not apply to Tier 1, Tier 2 drugs.	No prescription drug benefit coverage is available for this plan.
Preferred / Standard \$0 / \$2 \$0 / \$6	Preferred / Standard \$0 / \$2 \$0 / \$6	No prescription drug benefit coverage is available for this plan.
Preferred / Standard \$0 / \$12 \$0 / \$36 \$0 / \$36	Preferred / Standard \$0 / \$12 \$0 / \$36 \$0 / \$36	No prescription drug benefit coverage is available for this plan.
Preferred / Standard 24% / 24% 24% / 24%	Preferred / Standard 24% / 24% 24% / 24%	No prescription drug benefit coverage is available for this plan.
Preferred / Standard 25% / 25% 25% / 25%	Preferred / Standard 25% / 25% 25% / 25%	No prescription drug benefit coverage is available for this plan.
Preferred / Standard 25% / 25% N/A	Preferred / Standard 25% / 25% N/A	No prescription drug benefit coverage is available for this plan.
\$2,100	\$2,100	No prescription drug benefit coverage is available for this plan.

Benefits	H5521-120 Aetna Medicare Elite (PPO)	H5521-674 Aetna Medicare Elite Extra (PPO)
Catastrophic coverage:		
Generic and brand name drugs	\$0	\$0

H3312-064 Aetna Medicare Enhanced (HMO)	H5521-665 Aetna Medicare Enhanced (PPO)	H5521-320 Aetna Medicare Eagle Giveback (PPO)
\$0	\$0	No prescription drug benefit coverage is available for this plan.

* Deductible will apply to the following in-network services: inpatient hospital, inpatient psychiatric, skilled nursing facility, therapeutic radiology, outpatient hospital services (including observation), ambulatory surgical center (ASC), and dialysis. See the *Evidence of Coverage* for details.

*** The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). Eligibility for this benefit cannot be guaranteed based solely on your condition of end-stage renal disease. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.

**** While only your doctor can diagnose, prescribe or give medical advice, the [care management nurses/24-Hour Nurse Line] can provide information on a variety of health topics.

Disclaimers

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

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

Other [pharmacies/physicians/providers] are available in our network.

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

Aetna is part of the CVS Health® family of companies.

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The Aetna Medicare pharmacy network includes limited lower cost, preferred pharmacies in Suburban Arizona, Urban Kansas, Urban Missouri, Rural Michigan, Rural Nebraska, Rural North Dakota, Suburban West Virginia, and Suburban Puerto Rico. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call [1-833-859-6031](tel:1-833-859-6031) (TTY: [711](tel:711)) or consult the online *Pharmacy Directory* at [AetnaMedicare.com/findpharmacy](https://www.aetna.com/medicare/findpharmacy).

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

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)) (TTY users should call [1-877-486-2048](tel:1-877-486-2048)), 24 hours a day, 7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call [1-833-570-6670](tel:1-833-570-6670) (TTY: [711](tel:711)).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [1-833-570-6670](tel:1-833-570-6670) (TTY: [711](tel:711)).

Required disclaimer

If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement:

We do not offer every plan available in your

area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact [Medicare.gov](https://www.medicare.gov), 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)), or your local State Health Insurance Program to get information on all of your options.

If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement:

Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact [Medicare.gov](https://www.medicare.gov), 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)), or your local State Health Insurance Program for help with plan choices.

