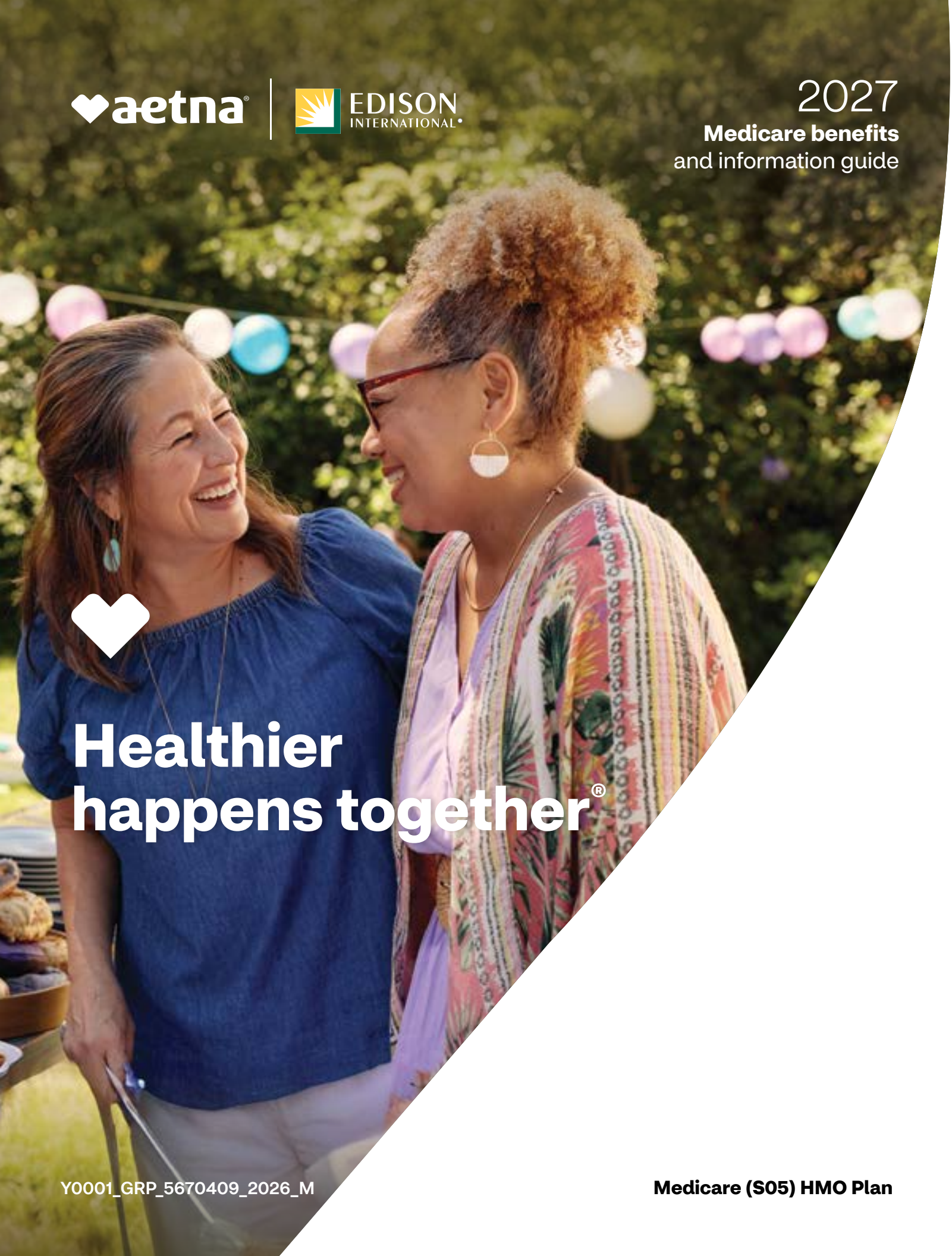


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2027
Medicare benefits
and information guide

Healthier happens together®

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Medicare (S05) HMO Plan

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Turn the page to learn more.

We've got your back every step of the way

So you can manage your Aetna® Medicare plan with confidence



Providers you trust

Our coverage helps connect you with the providers and hospitals you count on for care.



Added features

Our plans offer all of the benefits of Original Medicare, plus other benefits, programs and services.



And much more to help you feel your best

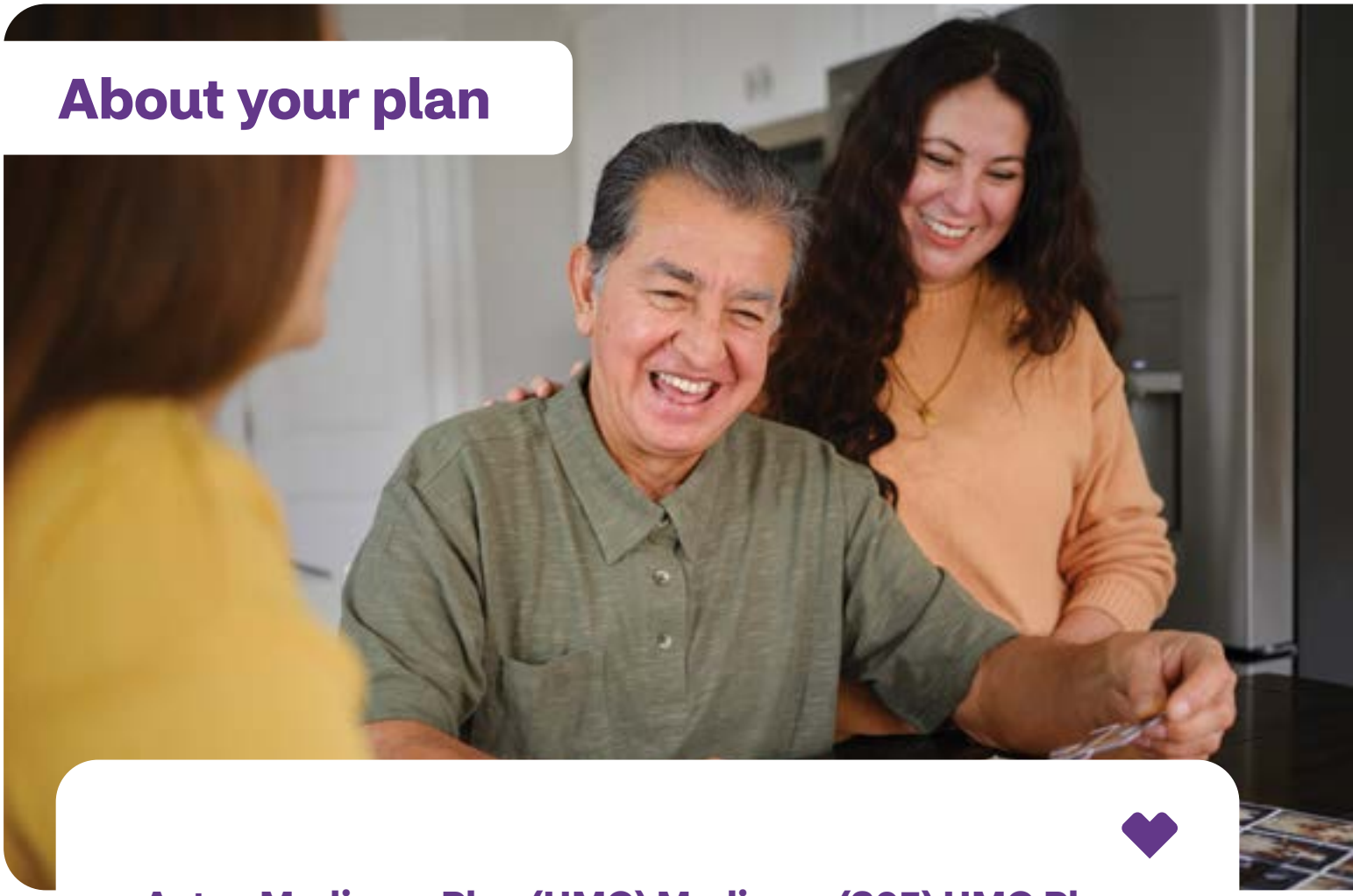
Read on to get the whole story.



Medicare 101

Understand how your plan works

About your plan



Aetna Medicare Plan (HMO) Medicare (S05) HMO Plan

An HMO is a health maintenance organization plan. **You'll have to use network providers for covered services.** It covers emergencies and out-of-area urgent care — even out of network. You'll typically pay a flat fee, or copay, for most covered services.

With an HMO plan, you'll have to choose a primary care provider (PCP). You'll also need a referral from your PCP to see a specialist.

We may choose a PCP for you if we don't know who your provider is. So be sure to share their name with us.

To find a provider that accepts the plan, just call us.

We're available at **1-833-943-5114 (TTY: 711)**, Monday–Friday, 5 AM–5 PM PT.



Summary of Benefits

Take a look at your plan

Aetna Medicare℠ Plan (HMO)

The **Summary of Benefits** shows expected costs for services and describes the benefits package. These details affect what you'll pay for your care. So be sure to review all the pages in this section.

More than one plan may be available to you.



Summary of Benefits 2027

SOUTHERN CALIFORNIA EDISON

Sponsored by Aetna Medicare Plan (HMO)
Medicare (S05) HMO Plan

Important Information

This is a summary of the services we cover from January 1, 2027 through December 31, 2027. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). To request a copy, contact:

Member Services
1-833-943-5114 (**TTY:** 711) Hours are 8 AM to 9 PM ET, Monday through Friday.

Are you eligible to enroll?

To join Aetna Medicare Plan (HMO), you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area. A complete list of service areas can be found in the *Evidence of Coverage* (EOC).



What You Should Know

Plan costs & information	In-network
Premium	Please contact your former employer for more information on your plan premium.
Annual Deductible	$0
	This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.
Annual Maximum Out-of-Pocket	$1,190
	The maximum out-of-pocket (MOOP) is the **most you'll pay** for the medical services we cover each year. **It's in place to protect you**. Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium doesn't count toward your MOOP.

PRIMARY BENEFITS	Your costs for in-network care
Hospital Care*	
Inpatient Hospital Care	$250 per stay The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Observation Stay	Your cost share for Observation Care is based upon the services you receive.
Frequency	per stay
Outpatient Hospital Services and Surgery	$0
Ambulatory Surgery Center	$0
Physician Services	
Primary Care Provider Visits	$30 Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.
Physician Specialist Visits	$30
Preventive Services	
Medicare-covered Preventive Services • Abdominal aortic aneurysm screenings • Alcohol misuse screenings and counseling • Annual Wellness visit • Bone mass measurements • Breast cancer screening: mammogram • Cardiovascular behavior therapy • Cardiovascular disease screenings • Cervical and vaginal cancer screenings • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screenings • Diabetes screenings • HIV screenings • Lung cancer screenings and counseling • Medicare Diabetes Prevention Program • Medical nutrition therapy • Obesity behavior therapy	$0

This continues on the next page

PRIMARY BENEFITS	Your costs for in-network care
Preventive Services (continued)	
• Prostate cancer screenings (PSA) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit	
Immunizations • Flu • Hepatitis B • Pneumococcal	$0
Additional Medicare Preventive Services • Diabetes self-management training • Digital rectal exam • EKG following welcome exam • Glaucoma screening	$0
Emergency and Urgent Medical Care	
Emergency Care	$125 (waived if admitted immediately)
Emergency Care Worldwide	$125 (waived if admitted)
Urgent Care	$30
Urgent Care Worldwide	$30
Diagnostic Procedures*	
Diagnostic Radiology (CT scans)	$0
Diagnostic Radiology (other than CT scans)	$0
Diagnostic Testing and Procedures	$0
Lab Services	$0
Outpatient X-rays	$0
Hearing Services	
Hearing Exam (routine)	$0
	Coverage: one exam every twelve months
Hearing Exam (Medicare-covered)	$30
Hearing Aid Reimbursement	$500 once every 12 months

PRIMARY BENEFITS	Your costs for in-network care
Dental Services*	
Dental Services	$30
	Medicare-covered benefits only
Vision Services	
Eye Exam (routine)	$0
	Coverage: one exam every year
Diabetic Eye Exam	$0
Eye Exam (Medicare-covered)	$30
Mental Health Services*	
Inpatient Mental Health Care	$250 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Mental Health Care	$30 (individual sessions)
	$30 (group sessions)
Partial Hospitalization Services	$30
Intensive Outpatient Service	$30
Inpatient Substance Use Disorder	$250 per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Substance Use Disorder	$30 (individual sessions)
	$30 (group sessions)
Skilled Nursing Services*	
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-100
	Limited to 100 days per Medicare benefit period. See the *Schedule of Cost Sharing* for details on the benefit periods.
Outpatient Rehabilitation Services	
Occupational Therapy Rehabilitation Services	$30
Physical and Speech Therapy Rehabilitation Services	$30
Ambulance* and Transportation Services	
Ambulance Services	$0

This continues on the next page

PRIMARY BENEFITS	Your costs for in-network care
Ambulance* and Transportation Services (continued)	
	Prior authorization rules may apply for non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.
Transportation (non-emergency)	Covered
	Coverage: up to 24 one-way trips per year with 60 miles allowed per trip.
Medicare Part B Prescription Drugs*	
Medicare Part B Prescription Drugs	$0

***These benefits may require prior authorization.**

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in-network care
Acupuncture Services	$30
	Medicare-covered benefits only
Allergy Shots	$0
Allergy Testing	$30
Blood	$0
	All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	$30
Chiropractic Services*	$20
	Medicare-covered benefits only
Diabetic Supplies*	$0
	Includes supplies to monitor your blood glucose from Accu-Chek/Roche and TRUE/Trividia, or from a non-preferred provider when a prior authorization is received.
Durable Medical Equipment (DME)*	$0
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.
Intensive Cardiac Rehabilitation Services	$30
Medical Supplies*	Your cost share is based upon the provider of services
Outpatient Dialysis Treatments*	$0
Podiatry Services	$30
	Medicare-covered benefits only
Prosthetic Devices*	$0
Pulmonary Rehabilitation Services	$20
Supervised Exercise Therapy (SET) for PAD	$20
Radiation Therapy*	$0

***These benefits may require prior authorization.**

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care
Acupuncture Services (non-Medicare covered)	$30
	Supplemental acupuncture services are covered for up to thirty visits every year under the following circumstance(s): in lieu of anesthesia and for treatment of chronic pain.
Chiropractic Services (non-Medicare covered)	$20
	Supplemental chiropractic services are covered for up to thirty visits every year.
Fitness Program	SilverSneakers®
Healthy Rewards	Covered
In-Home Support Services	$0
Coverage Type	UF Chronic Condition Post Discharge
Number of Hours	6 hours
Frequency	per discharge
Vendor	The Helper Bees
	You may be eligible to receive in-home support services after a qualifying discharge.
Meals	$0 After discharge from an inpatient stay to your home, you may be eligible to receive up to 28 home-delivered meals over a 14-day period.
Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Over-the-Counter Items	$0
Over-the-Counter Allowance	$45
Over-the-Counter Frequency	quarterly
Podiatry Services (non-Medicare covered)	$30
	Supplemental podiatry services are covered.
Resources for Living®	This program is offered to help you locate resources for everyday needs.
Routine Physical	$0
	A routine physical exam is offered once per calendar year.
Teladoc™	$0

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care
	Telemedicine services with a Teladoc provider. State mandates may apply.
Telehealth PCP	$30
Telehealth Specialist	$30
Telehealth Occupational Therapy Service	$30
Telehealth PT and ST Services	$30
Telehealth Other Health Care Providers	$30
Telehealth Individual Mental Health*	$30
Telehealth Group Mental Health*	$30
Telehealth Individual Psychiatric Services*	$30
Telehealth Group Psychiatric Services*	$30
Telehealth Individual Outpatient Substance Use Disorder*	$30
Telehealth Group Outpatient Substance Use Disorder*	$30
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services*	$30
Telehealth Urgent Care	$30
Wigs	$0
Maximum	$400
Frequency	every year

***These benefits may require prior authorization.**

MEDICAL DISCLAIMERS

For more information about Aetna plans, go to **SCEMAPlans.aetnamedicare.com** or call Member Services toll-free at **1-833-943-5114** (**TTY: 711**). Hours are 8 AM to 9 PM EST, Monday through Friday.

Not all HMO plans are available in all areas.

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.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the *Evidence of Coverage* (EOC). You can request a copy of the EOC by contacting Member Services at **1-833-943-5114** (**TTY: 711**). Hours are 8 AM to 9 PM EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services not performed by your Aetna Medicare network doctor, except in an emergency or urgent situation
- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your *Evidence of Coverage*.
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

PLAN DISCLAIMERS

Aetna Medicare is a HMO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). 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.

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.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

SilverSneakers is a registered trademark of Tivity Health, Inc. ©2026 Tivity Health, Inc. All rights reserved.

Medicare rules don't allow earned rewards to be used for Medicare-covered goods or services, including medical or prescription drug out-of-pocket costs. Earned rewards may not be used to pay for medical copays, prescription costs, or any other Medicare covered good or services. Earned rewards may also not be used to pay for products such as on alcohol, tobacco, cannabis, firearms, lottery, gift cards or be converted to cash. Rewards earned may be considered taxable income. Please consult your tax adviser if you have any questions regarding the taxability of rewards. The 2027 Aetna Healthy Rewards program is only applicable to active members with eligible MA and/or MAPD plans. Qualifying participants who are eligible to perform the program activities may earn rewards by completing all or some of the program activities. Rewards will be distributed to participants and available to redeem on their Extra Benefits Card. The 2027 Aetna Healthy Rewards program is available to our members until the last day of the year. You will need to earn and redeem your reward by December 15, 2027 or the date you leave the plan, whichever comes first. Participants should check the terms of their Schedule of Cost Sharing (SOC) prior to participating in any program activities. Except as set forth in the SOC, Aetna shall not be responsible for any costs associated with, or arising from, a participant's performance of program activities. Your participation in Aetna Healthy Rewards program is voluntary and does not affect your benefits from your Aetna health plan. Eligibility is limited to the Aetna member that this communication was addressed to. Subject to benefits and eligibility verification.

Teladoc Health is not available to all members. Teladoc Health and Teladoc Health physicians are independent contractors and are not agents of Aetna. Visit **TeladocHealth.com/Aetna** for a complete description of the limitations of Teladoc Health services. Teladoc, Teladoc Health and the Teladoc Health logo are registered trademarks of Teladoc Health, Inc.

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** (TTY users should call **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.

If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

You can read the *Medicare & You 2027* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**www.medicare.gov**) or by calling 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

You can also visit our website at **SCEMAPlans.aetnamedicare.com**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

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Star Ratings

Plan ratings from members, providers and Medicare

Here's how Star Ratings work

The Centers for Medicare & Medicaid Services (CMS) uses information from member satisfaction surveys, plans and health care providers to rate Medicare plans and prescription drug plans (Part D).

Medicare plan ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from providers and hospitals that work with the plan

Each plan receives a rating from one star (lowest) to five stars (highest). Star Ratings are calculated each year and may change from one year to the next.



Turn the page to see how highly our plans rate.

IMPORTANT INFORMATION:

2027 Medicare Star Ratings

Official U.S. Government Medicare Information

Aetna Medicare - H5522

For 2027, Aetna Medicare - H5522 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★½
Health Services Rating:	★★★★½
Drug Services Rating:	★★★★☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online
Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?
Contact Aetna Medicare Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 800-307-4830 (toll-free) or 711 (TTY). Current members please call 888-267-2637 (toll-free) or 711 (TTY).

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After enrollment

See what happens next

What happens next

You'll hear from us within about 30 days after you enroll in the plan. Here's what you can expect:



Plan confirmation and acceptance letter

This includes info about your plan's features. We'll send it to you once the Centers for Medicare & Medicaid Services (CMS) approves your enrollment. **You'll get your letter by mail.**

Plan member ID card

This card — not your red, white and blue Medicare card — should be used each time you visit the doctor, hospital or pharmacy. **You'll get your member ID card by mail. You can also find it online.**

Evidence of Coverage (EOC)

This is a complete description of your Medicare plan coverage and your member rights. **You'll find your EOC online.**

Schedule of Cost Sharing (SOC)

This outlines costs that you pay out of your own pocket. This can include deductibles, coinsurance, copayments or similar charges. **Depending on your plan, you'll either get your SOC in the mail or receive instructions to find it online.**

Healthy Home Visit

We'll call you to schedule a Healthy Home Visit. You'll get in-home advice from a licensed health care professional on how to reach your health goals.

Quick tip:

Once you receive your plan member ID card, be sure to register for your secure member website. There, you can provide your email address and opt in to get important updates from us right in your inbox.

Helpful resources

Keep these handy so you can refer back to them at any time.

Call us

We're available at **1-833-943-5114 (TTY:711)**.
We're here Monday–Friday, 5 AM–5 PM PT.



Get info online

- Want more details about the plan and additional wellness programs? Looking for a provider or hospital?

Visit your plan website to find all that and more.
SCEMAPlans.AetnaMedicare.com

← Or just scan the QR code.

- Visit **Medicare.gov** for more information about how Medicare works.

How to scan a QR code

It's easy as 1-2-3

1. **Open the camera app on your smartphone.**
2. **Point your camera at the QR code.**
   Your camera will automatically scan the code and show a link.
3. **Tap the link.**
   You'll be taken to your plan info.



Download the Aetna Health℠ app

Manage your plan the easy way with the Aetna Health app.

- View claims
- Track spending
- Access your digital member ID card, and much more

Don't have the app? Get it today:

GET IT ON Google Play

Download on the App Store

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Google Play is a trademark of Google LLC.

Aetna®, CVS Caremark® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Aetna Medicare is an HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Every year, Medicare evaluates plans based on a 5-star rating system.

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.

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.

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.

Other providers are available in our network.

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** (TTY users should call **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.

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Important information about your enrollment in a Medicare plan

As an Aetna Medicare member, you agree to the following:
Aetna Medicare is a Medicare plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B and continue to pay my Part B premium. I can only be in one Medicare plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform Aetna of any prescription drug coverage that I have or may get in the future.

I understand that if I don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the (entire) year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, during the Annual Enrollment Period, which is October 15 through December 7 of every year), or under certain special circumstances.

The Aetna Medicare plan serves a specific service area. If I move out of the area that the Aetna Medicare plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I am a member of the Aetna Medicare plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the Aetna Medicare plan when I get it to know which rules I must follow to get coverage with this Medicare plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

HMO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, I must get all my health care from the Aetna Medicare plan, except for emergency or urgently needed services or out of area dialysis services.

Services authorized by the Aetna Medicare plan and other services contained in my Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES**.

PPO plans: I understand that beginning on the date Aetna Medicare plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare plan and other services contained in my Aetna Medicare plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization when required by the plan, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES**.

I understand that beginning on the date the Aetna Medicare plan coverage begins, I must get all of my health care from Aetna Medicare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the Aetna Medicare plan and other services contained in my Aetna Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE AETNA MEDICARE PLAN WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with the Aetna Medicare plan, he/she may be paid based on my enrollment in the Aetna Medicare plan.

Release of information
By joining this Medicare health plan, I acknowledge that the Aetna Medicare plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Aetna Medicare plan will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be disenrolled from the plan.

Aetna Resources For Living℠ is the brand name used for products and services offered through the Aetna group of companies (Aetna). The EAP is administered by Aetna Behavioral Health, LLC, and in California for Knox-Keene plans, and Health and Human Resources Center, Inc.

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