Summary of Benefits 2027

ROCHESTER AREA SCHOOL HEALTH PLAN I

Sponsored by Aetna Medicare Plan (PPO)
Medicare (P01) ESA PPO 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
1-888-267-2637 (**TTY:** 711) Hours are 8 AM to 9 PM ET, Monday through Friday.

Are you eligible to enroll?

To join Aetna Medicare Plan (PPO), 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

Primary Care Provider (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your provider in order to see you.

Prior Authorizations: Your provider will work with us to get approval before you receive certain services. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Plan costs & information	Network & Out-of-network providers
Premium	Please contact your former employer/union/ trust for more information on your plan premium.
Annual Deductible	$200
	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.
Services Exempt from Deductible	Deductible waived for Preventive Services, Part B Drugs - Insulin, Continuous Glucose Monitors (CGMs), Emergency Room Visits, Emergency Ambulance, Urgent Care, some Medicare-covered diagnostic tests and labs (Urine protein, Prothrombin testing, HBA1C, FIT Screening, Fundus Testing, gFOBT Testing and COVID lab tests), Teladoc, and Wigs.
Annual Maximum Out-of-Pocket	$2,500
	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 and out-of-network care
Hospital Care*	
Inpatient Hospital Care	$225 per day, days 1-5; $0 unlimited additional days
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Observation Stay	$50
	Frequency: per stay
Outpatient Hospital Services and Surgery	$200
Ambulatory Surgery Center	$200
Primary Care Provider and Specialist Services	
Primary Care Provider Visits	$40
	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.
Specialist Visits	$60
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 behavioral 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 therapy	$0

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PRIMARY BENEFITS	Your costs for in and out-of-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/Influenza • Hepatitis B • Pneumonia	$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	$115 (waived if admitted within 24 hours)
Emergency Care Worldwide	$115 (waived if admitted)
Urgent Care	$40
Urgent Care Worldwide	$40
Diagnostic Procedures*	
Diagnostic Radiology (CT scans)	$200
Diagnostic Radiology (other than CT scans)	$200
Diagnostic Testing and Procedures	$100
Lab Services	$0
Outpatient X-rays	$10
Hearing Services	
Hearing Exam (routine)	$0 Coverage: 1 exam every 12 months
Hearing Exam (Medicare-covered)	$60

PRIMARY BENEFITS	Your costs for in and out-of-network care
Hearing Aid Reimbursement	$500 for two hearing aids every 36 months
Dental Services*	
Dental Services	$60
	Medicare-covered benefits only
Vision Services	
Eye Exam (routine)	$0
	Coverage: one exam every year
Diabetic Eye Exam	$0
Eye Exam (Medicare-covered)	$55
Eyewear Reimbursement	$100 once every 12 months
Mental Health Services*	
Inpatient Mental Health Care	$225 per day, days 1-5; $0 unlimited additional days
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Mental Health Care	$40 (individual sessions)
	$40 (group sessions)
Partial Hospitalization Services	$40
Intensive Outpatient Service	$60
Inpatient Substance Use Disorder	$225 per day, days 1-5; $0 unlimited additional days
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Outpatient Substance Use Disorder	20% (individual sessions)
	20% (group sessions)
Skilled Nursing Services*	
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $218 per day, days 21-100
	Limited to 100 days per Medicare benefit period. See the *Schedule of Cost Sharing* for details on the benefit periods.
Outpatient Rehabilitation Services	

PRIMARY BENEFITS	Your costs for in and out-of-network care
Occupational Therapy Rehabilitation Services	$10
Physical and Speech Therapy Rehabilitation Services	$10
Ambulance* and Transportation Services	
Ambulance Services	$175
	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. Services should be scheduled through our authorized vendor, MTM Health.
Worldwide Emergency Transportation (non-Medicare covered)	$175
Medicare Part B Prescription Drugs*	
Medicare Part B Prescription Drugs	20%
Medicare Part B Prescription Drugs - Insulin	20% up to $35

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

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in and out-of-network care
Acupuncture Services	$60
	Medicare-covered benefits only
Allergy Shots	20%
Allergy Testing	$60
Blood	$0
	All components of blood are covered beginning with the first pint.
Cardiac Rehabilitation Services	$0
Chiropractic Services*	$15
	Medicare-covered benefits only
Continuous Glucose Monitor	$0
Continuous Glucose Supplies	$0
Diabetic Supplies*	$0
Durable Medical Equipment (DME)*	20%
Home Health Agency Care*	$0
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.
Intensive Cardiac Rehabilitation Services	$0
Medical Supplies*	20%
Outpatient Dialysis Treatments*	$0
Podiatry Services	$60
	Medicare-covered benefits only
Prosthetic Devices*	20%
Pulmonary Rehabilitation Services	$10
Supervised Exercise Therapy (SET) for PAD	$10
Radiation Therapy*	$10
***These benefits may require prior authorization.**	

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Basic SilverSneakers® Program	You are covered for a basic membership to any SilverSneakers® authorized participating fitness facility. Additionally, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers.
Fitness Reimbursement	$150
Frequency	every year
In-Home Support Services	In-Home Support Provides in home help for every day needs and activities of daily living.
Coverage Type	Post Discharge
Number of Hours	6 hours
Frequency	per discharge
Vendor	Services must be coordinated through our authorized vendor, The Helper Bees.
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.
Podiatry Services (non-Medicare covered)	$60
	Supplemental podiatry services are covered for up to 6 visits every year.
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.
Smoking and Tobacco Use Cessation Supplies	$0
Frequency	unlimited visits every year
Teladoc™	$0
	Telemedicine services with a Teladoc provider. State mandates may apply.
Telehealth PCP	$40
Telehealth Specialist	$40
Telehealth Occupational Therapy Service	$10

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in and out-of-network care
Telehealth PT and ST Services	$10
Telehealth Other Health Care Providers	$40
Telehealth Individual Mental Health*	$40
Telehealth Group Mental Health*	$40
Telehealth Individual Psychiatric Services*	$40
Telehealth Group Psychiatric Services*	$40
Telehealth Individual Outpatient Substance Use Disorder*	20%
Telehealth Group Outpatient Substance Use Disorder*	20%
Telehealth Kidney Disease Education Services	$0
Telehealth Diabetes Self-Management Training	$0
Telehealth Opioid Treatment Program Services*	20%
Telehealth Urgent Care	$40
Wigs	$0
Maximum	$400
Frequency	every year
***These benefits may require prior authorization.**	

MEDICAL DISCLAIMERS

For more information about Aetna plans, go to **AetnaRetireePlans.com** or call Member Services toll-free at **1-888-267-2637** (**TTY: 711**). Hours are 8 AM to 9 PM ET, Monday through Friday.

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 **1-888-267-2637** (**TTY: 711**). Hours are 8 AM to 9 PM ET, Monday through Friday.

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

- 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

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

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

Aetna will pay any non-contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare-covered services under the plan.

PLAN DISCLAIMERS

Aetna Medicare is a PPO 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.

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.

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

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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 **AetnaRetireePlans.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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Notice of Availability (NOA)

TTY: 711

To access language assistance services and appropriate auxiliary aids and services at no cost to you, call the number on this document. (English)

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للوصول إلى خدمات المساعدة اللغوية والمساعدات والخدمات المساندِة المناسبة دون أي تكلفة عليك، اتصل بالرقم الوارد في هذا المستند. (Arabic)

如欲獲得免費的語言輔助服務以及適當的輔助工具和服務，請撥打本文件上的電話號碼。 (Chinese)

Pou w jwenn aksè ak sèvis sipò lang gratis ansanm ak sèvis asistans ak sipò apwopriye, tanpri rele nimewo ki endike sou dokiman sa a. (French Creole)

Pour accéder aux services d'assistance linguistique et aux aides et services auxiliaires appropriés sans frais à votre charge, appelez le numéro indiqué dans ce document. (French)

Um Sprachunterstützung sowie geeignete Hilfsmittel und Dienstleistungen kostenlos in Anspruch zu nehmen, rufen Sie bitte die auf diesem Dokument angegebene Nummer an. (German)

તમારા માટે વિના મૂલ્યે ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો તથા સેવાઓ મેળવવા માટે, આ દસ્તાવેજ પર આપેલા નંબર પર કૉલ કરો. (Gujarati)

No ke komo ʻana i nā lawelawe kōkua ʻōlelo a me nā mea kōkua kūpono a me nā lawelawe me ka uku ʻole iā ʻoe, e kelepona i ka helu ma kēia palapala. (Hawaiian)

Kom siv tau cov kev pab cuam txhais lus thiab cov khoom pab kom hnov lus thiab cov kev pab cuam yam tsis sau nqi ntawm koj, hu tus npawb xov tooj ntawm daim ntawv thov no. (Hmong)

Contattare il numero nel presente documento per accedere, senza costi aggiuntivi, ai servizi di assistenza linguistica e ad idonei aiuti ausiliari. (Italian)

言語支援サービスや適切な補助具やサービスを無料で利用するには、こちらの文書の電話番号までお電話ください。 (Japanese)

လၢတၢ်ကမၤနှံသူကိုဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်ဒီးတၢ်မၤစၢၤလၢအကဲထိဉ်သ့လၢအဖိးမံတဖဉ်ဒီးတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတလိဉ်နဟ့ဉ်အပှၤအဂီၢ်နှဉ်,ကိးဘဉ်နီၢ်ဂံၢ်လၢလံာ်တဘ့ဉ်အံၤအလိၤတက့ၢ်. (Karen)

ដើម្បីទទួលបានសេវាកម្មជំនួយផ្នែកភាសា និងការគាំទ្រ និងសេវាកម្មបន្ថែមសមស្របដោយមិនគិតថ្លៃ សម្រាប់អ្នក សូមទូរសព្ទទៅលេខនៅលើឯកសារនេះ។ (Khmer)

언어 지원 서비스와 적절한 보조 지원 및 서비스를 무료로 이용하려면 본 문서에 나와 있는 번호로 전화해 주시기 바랍니다. (Korean)

ເພື່ອເຂົ້າເຖິງການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ອຸປະກອນຊ່ວຍໃນການຟັງ ແລະ ການບໍລິການອື່ນໆ ໂດຍທ່ານບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, ໃຫ້ໂທຫາເບີໃນເອກະສານນີ້. (Lao)

Tajaajilawwan gargaarsa afaanii fi tajaajilawwan gargaarsaa dabalataa mijaawaa ta'an kaffaltii tokko malee argachuuf, lakkoofsa sanada kana irra jirutti bilbilaa. (Oromo)

(Persian) برای دسترسی رایگان به خدمات کمک زبانی و وسایل و خدمات کمکی مناسب، با شماره درجشده در این سند تماس بگیرید.

Aby skorzystać z usług pomocy językowej oraz odpowiednich środków pomocniczych i usług bez ponoszenia żadnych kosztów, zadzwoń pod numer podany w niniejszym dokumencie. (Polish)

Para aceder, sem custos para si, a serviços de assistência linguística e a auxílios e serviços de apoio adequados, ligue para o número indicado neste documento. (Portuguese)

Чтобы бесплатно воспользоваться услугами языковой поддержки, а также соответствующими вспомогательными средствами и услугами, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para tener acceso a los servicios de asistencia en otros idiomas y a las ayudas y servicios auxiliares adecuados sin costo para usted, llame al número que figura en este documento. (Spanish)

Upang ma-access ang mga serbisyo sa tulong sa wika at mga angkop na pantulong na kagamitan at serbisyo nang hindi ka gagastos, tawagan ang numero sa dokumentong ito. (Tagalog)

หากต้องการเข้าถึงบริการช่วยเหลือด้านภาษาและอุปกรณ์ช่วยเหลืออื่น ๆ ทีเหมาะสมโดยไม่เสียค่าใช้จ่าย โปรดติดต่อหมายเลขทีระบุในเอกสารนี (Thai)

Để tiếp cận các dịch vụ hỗ trợ ngôn ngữ, công cụ hỗ trợ và dịch vụ phụ trợ phù hợp miễn phí dành cho quý vị, hãy gọi đến số điện thoại ghi trên tài liệu này. (Vietnamese)