School Employees Retirement System of Ohio

Aetna Medicare℠ Plan (PPO)
SERS PPO Plan

Benefits and Premiums are effective January 1, 2023 through December 31, 2023

SUMMARY OF BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Primary Care Physician (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 doctor in order to see you.

Prior Authorizations: Your doctor 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 FEATURES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Monthly Premium	Please contact School Employees Retirement System of Ohio for more information on your plan premium.	
Annual Deductible 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.	$0	$0
Annual Maximum Out-of-Pocket Amount	**Network Services:**	**Network and out-of-network services:**
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses.	$3,000	$6,700 for in and out-of-network services combined

HOSPITAL CARE*	This is what you pay for network providers.	This is what you pay for out-of-network
Inpatient Hospital Care	$150 per day, days 1-5; $0 unlimited additional days	20% 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	Your cost share for Observation Care is based upon the services you receive
Frequency:	per stay	per stay
Outpatient Services & Surgery	15% coinsurance, maximum $200 cost share per date of service	20%
Ambulatory Surgery Center	15% coinsurance, maximum $200 cost share per date of service	20%

PHYSICIAN SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Primary Care Physician Visits	$10	20%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	$30	20%

PREVENTIVE CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare-covered Preventive Services	$0	20%

• Abdominal aortic aneurysm screenings
• Alcohol misuse screenings and counseling
• Annual Well Visit - One exam every 12 months.
• Bone mass measurements
• Breast exams
• Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.
• Cardiovascular behavior therapy
• Cardiovascular disease screenings
• Cervical and vaginal cancer screenings (Pap) - one routine GYN visit and pap smear every 24 months.
• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
• Depression screenings
• Diabetes screenings
• HBV infection screening
• Hepatitis C screening tests
• HIV screenings
• Lung cancer screenings and counseling
• Nutrition therapy services
• Obesity behavior therapy
• Pelvic Exams - one routine GYN visit and pap smear every 24 months.
• Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service
• Prostate cancer screenings (PSA) - for all male patients aged 50 and older (coverage begins the day after 50th birthday)
• Sexually transmitted infections screenings and counseling
• Tobacco use cessation counseling
• Welcome to Medicare preventive visit

PREVENTIVE CARE (cont.)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
• Medicare Diabetes Prevention Program - 12 months of core session for program eligible members with an indication of pre-diabetes.	$0	0%
Immunizations • Flu • Hepatitis B • Pneumococcal	$0	$0
Additional Medicare Preventive Services • Barium enema - one exam every 12 months. • Diabetes self-management training (DSMT) • Digital rectal exam (DRE) • EKG following welcome exam • Glaucoma screening	$0	20%

EMERGENCY AND URGENT MEDICAL CARE	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Emergency Care; Worldwide (waived if admitted)	$100	$100
Urgently Needed Care; Worldwide	$40	$40

DIAGNOSTIC PROCEDURES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Diagnostic Radiology MRI and CT scans	$25	20%
Lab Services	$0	20%
Diagnostic testing & procedures	$25	20%
Outpatient X-rays	$25	20%

HEARING SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Routine Hearing Screening We cover one every twelve months	$0	20%
Medicare Covered Hearing Examination	$30	20%
DENTAL SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Medicare Covered Dental* Non-routine care covered by Medicare.	$30	20%
VISION SERVICES	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Routine Eye Exams One annual exam every 12 months.	$0	20%
Diabetic Eye Exams	$0	20%
MENTAL HEALTH SERVICES*	**This is what you pay for network providers.**	**This is what you pay for out-of-network providers.**
Inpatient Mental Health Care	$150 per day, days 1-5; $0 unlimited additional days	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Mental Health Care Individual and Group visits	$30	20%
Partial Hospitalization	$30	20%
Inpatient Substance Abuse	$150 per day, days 1-5; $0 unlimited additional days	20% per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Outpatient Substance Abuse Individual and Group visits	$30	20%

SKILLED NURSING SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-10; $25 per day, days 11-20; $50 per day, days 21-100	$0 per day, days 1-10; $25 per day, days 11-20; $50 per day, days 21-100

Limited to 100 days per Medicare Benefit Period.
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Outpatient Rehabilitation Services	$15	20%

(Speech, physical, and occupational therapy)

AMBULANCE SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Ambulance Services	$80	$80

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 SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Transportation (non-emergency)	Not Covered	

MEDICARE PART B PRESCRIPTION DRUGS*	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Medicare Part B Prescription Drugs	$0	20%

ADDITIONAL PROGRAMS AND SERVICES	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Allergy Shots	$0	20%
Allergy Testing	$20 PCP/$30 Specialist	20%
Blood All components of blood are covered beginning with the first pint.	0%	20%
Cardiac Rehabilitation Services	$15	20%
Chiropractic Services* Medicare covered benefits only.	$20	20%
Diabetic Supplies* Includes supplies to monitor your blood glucose.	$0	20%
Durable Medical Equipment/ Prosthetic Devices*	20%	20%
Home Health Agency Care*	$0	$0
Hospice Care	Covered by Original Medicare at a Medicare certified hospice. Members who have Medicare Part B Only - Covered by Aetna at a Medicare certified hospice.	
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Medicare Covered Acupuncture	$30	20%
Outpatient Dialysis Treatments*	$0	$0
Podiatry Services Medicare covered benefits only.	$30	20%
Pulmonary Rehabilitation Services	$15	20%
Radiation Therapy*	$25	20%

ADDITIONAL PROGRAMS (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Fitness Benefit	SilverSneakers	
Resources For Living®	Covered	
For help locating resources for every day needs.		
Teladoc™	$0	
Telemedicine services with a Teladoc™ provider. State mandates may apply.		
Telehealth	Covered	
Telemedicine Services. Member cost share will apply based on services rendered.		
Telehealth PCP	$10	20%
Telehealth Specialist	$30	20%
Telehealth Other Health care Providers	$30	20%
Telehealth Individual Mental Health	$30	20%
Telehealth Group Mental Health	$30	20%
Telehealth Individual Psychiatric Services	$30	20%
Telehealth Group Psychiatric Services	$30	20%
Telehealth Urgent care	$40	$40
Wigs*	$0	$0
Maximum	unlimited	
Frequency	unlimited	

ADDITIONAL SERVICES (NOT COVERED BY ORIGINAL MEDICARE)	This is what you pay for network providers.	This is what you pay for out-of-network providers.
Compression Stockings	$20	20%
Routine Physical Exams	$0	20%
One exam per calendar year		

Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Medical Disclaimers

For more information about Aetna plans, go to **SERS.AetnaMedicare.com** or call Member Services at toll-free at 1-866-282-0631 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Not all PPO Plans are available in all areas

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

Participating physicians, hospitals and other 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 1-866-282-0631 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, 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 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.

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 HMO, 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 physicians, hospitals and other 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 join the Aetna Medicare Advantage Plan (PPO), you must meet the requirements of the plan sponsor/your former employer, be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

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

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.

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

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

You can read the Medicare & You 2023 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 (http://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.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-282-0631 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-282-0631 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-866-282-0631 (TTY: 711).

Plan Disclaimers (cont.)

You can also visit our website at http://SERS.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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