REHP 2024 OVERVIEW

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REHP Non-Medicare 2024

- Non-Medicare medical and Rx plan offerings remain the same for 2024.
- Non-Medicare copays and deductibles are unchanged for 2024.

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Aetna Medicare Open Access PPO

The contract for the Aetna Medicare Open Access PPO has been renewed through 2026.

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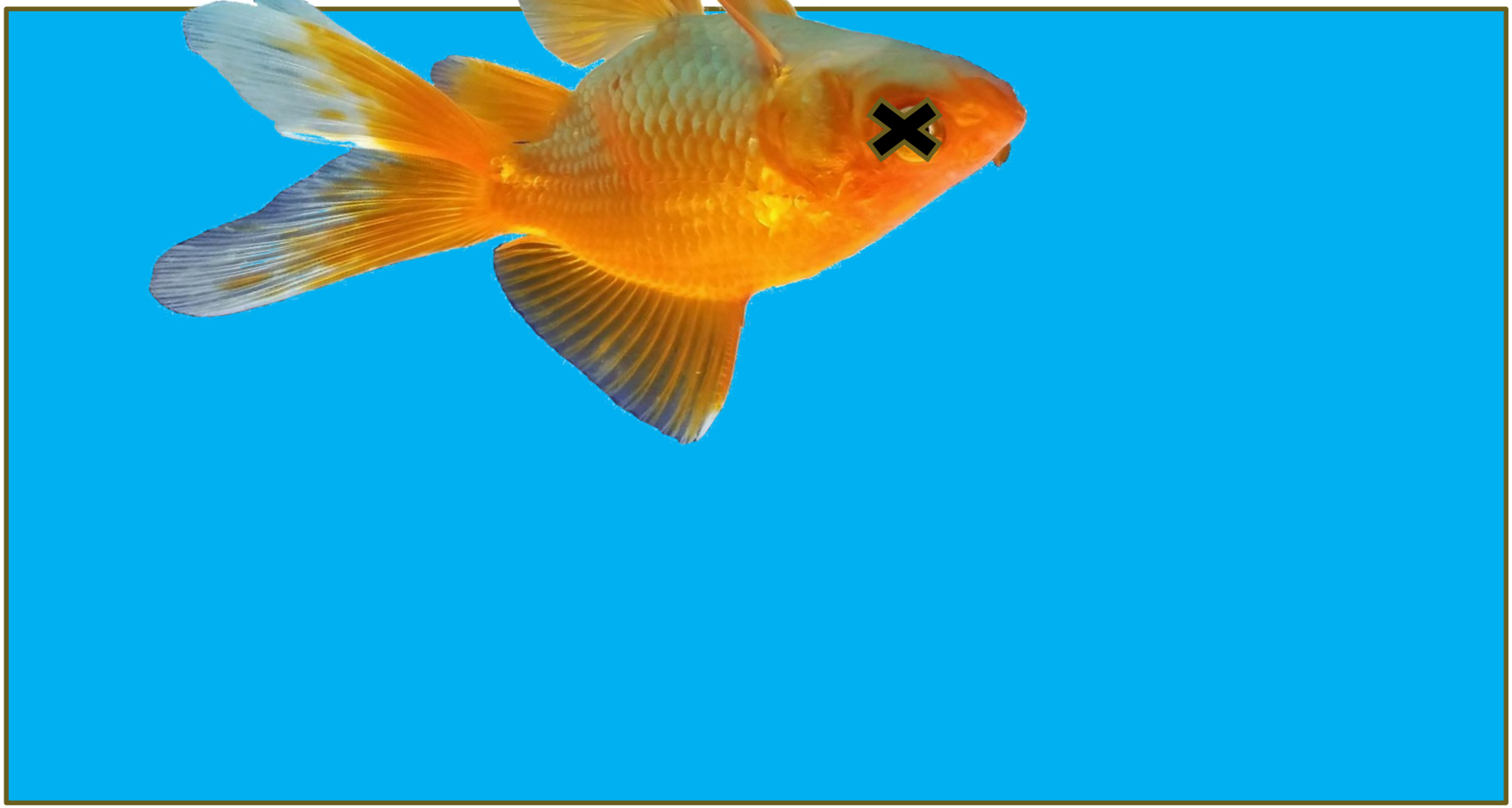
REHP Medicare 2024



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Medicare 2024

- The REHP Aetna Medicare Open Access PPO is not offered to the public but shares a plan number with a public Aetna plan (H5521).
- The public Aetna plan received a lower Medicare star rating.

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Medicare 2024

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2023 Medicare Star Ratings

Aetna Medicare - H5521

For 2023, Aetna Medicare - H5521 received the following Star Ratings from Medicare:

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

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

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Star Rating and the REHP

- Due to the association with a plan that has a lower star rating, a "change" had to be made with the REHP plan.
- The REHP Aetna Medicare Open Access PPO is technically new but is exactly the same in terms of plan design, copays, and benefits.
- New ID cards will be mailed in December.

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Star Rating and the REHP

- A letter will be mailed to all Medicare eligible members explaining the change.
- In addition, the change will be addressed in the Open Enrollment newsletter.
- Plan design* and costs are NOT CHANGING in 2024.

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Aetna Medicare Open Access PPO

Call 1.800.954.0684 at 10 am on October 27th or at 2 pm on November 3rd for a free Aetna educational call.

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What is changing in 2024?

- Costs for $5 State Paid REHP members & Survivor Spouse members will change.
- Medicare Part B premiums and Medicare deductible may change.
- Potential for changes with specific prescriptions on the Rx formulary (notices will be sent if that's the case).

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Open Enrollment

- **Non-Medicare**- October 16, 2023 – November 3, 2023

- **Medicare**- October 23, 2023 – November 10, 2023

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Understanding the Deductible

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Understanding the Deductible

The deductible is the amount you owe for health care services before the plan begins to pay.

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Understanding the Deductible

The deductible is different depending on the plan in which you are enrolled.

- **Aetna Medicare Open Access PPO**- $226
- **Choice PPO**- $400 single/$800 family
- **Basic PPO–** $1,500 single/$3,000 family
- **Custom HMO**- n/a

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Understanding the Deductible

For both non-Medicare and Medicare REHP members the deductible is annual and will reset every January 1st.

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Understanding the Deductible

- The deductible does not apply to certain services.
- Check the REHP Handbook to see when the deductible applies.
- Medicare members can also check Aetna's plan materials.

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Understanding the Deductible

Three REHP Medicare members are all sent to get an x-ray which costs $200. Each one pays a different amount. Why?

	Moe	Larry	Curly
Annual deductible	$226	$226	$226
Amount already paid toward deductible in same calendar year	$0	$150	$226
Amount charged for x-ray	$200	$50	$0
Deductible remaining	$26	$26	$0

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Understanding the Deductible

- Don’t confuse the deductible with the Out of Pocket Max!
- The OOP Max is a protection, meaning once you reach the OOP Max dollar amount, you will no longer pay for services in the calendar year.
    - Aetna Medicare PPO- $2,500
    - Choice & Basic PPO- $9,100/$18,200
    - Custom HMO- $9,100/$18,200

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Understanding REHP Costs

What should I do if I disagree with the amount being charged or have any questions concerning my REHP benefits?

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Understanding REHP Costs

What should I do if I disagree with the amount being charged or have any questions concerning my REHP benefits?

Call!

- Your REHP medical plan; or
- Health Advocate (1.855.855.4238); or
- PEBTF (1.800.522.7279).

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Understanding REHP Benefits

Educate yourself on your REHP benefits:

- REHP newsletters
- REHP Handbook
- Required Medicare mailings
  - Summary of Benefits

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Summary of Benefits

aetna™

THE RETIRED EMPLOYEES HEALTH PROGRAM (REHP)

Aetna Medicare℠ Plan (PPO)
Medicare Open Access PPO Plan

HOSPITAL CARE*	This is what you pay for network & out-of-network providers.
Inpatient Hospital Care	$0 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 per stay.
Outpatient Services & Surgery	$0
Ambulatory Surgery Center	$0
PHYSICIAN SERVICES	**This is what you pay for network & out-of-network providers.**
Primary Care Physician Visits	$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
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers.**
Medicare-covered Preventive Services • 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	$0

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Understanding REHP Benefits

Educate yourself on your REHP benefits:

- REHP newsletters
- REHP Handbook
- Required Medicare mailings
  - Summary of Benefits
  - Schedule of Cost Sharing

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Schedule of Cost Sharing

Services that are covered for you	What you must pay when you get these services
	supplies. $0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. We also cover some telehealth visits with psychiatric and mental health professionals. See **"Physician/Practitioner services, including doctor's office visits"** for information about telehealth outpatient mental health care. **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an out-of-network provider. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.**	$20 copay for each Medicare-covered outpatient mental health service provided by a psychiatrist (individual session). $20 copay for each Medicare-covered outpatient mental health service provided by a psychiatrist (group session). $20 copay for each Medicare-covered outpatient mental health service provided by a mental health professional other than a psychiatrist (individual session). $20 copay for each Medicare-covered outpatient mental health service provided by a mental health professional other than a psychiatrist (group session).
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization rules may apply for network services. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of the service when provided by an**	$20 copay for each Medicare-covered physical or speech therapy visit. $20 copay for each Medicare-covered occupational therapy visit.

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Understanding REHP Benefits

Educate yourself on your REHP benefits:

- REHP newsletters
- REHP Handbook
- Required Medicare mailings
  - Summary of Benefits
  - Schedule of Cost Sharing
  - Evidence of Coverage

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Evidence of Coverage

- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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Contact Info

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RA-rehp@pa.gov

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Questions

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