Section 3: Plans and Premiums

Please review this section for the coverage features and premiums of the plans for Medicare and non-Medicare enrollees. Plan options and premiums are based on Medicare status.

Prescription Plan Features for 2024	SilverScript (Medicare) CVS Caremark (Non-Medicare)	
Annual Brand-Name Deductible per Enrollee (Generic drug costs are not subject to nor applied to the deductible.)	$275 for covered brand-name drugs	
Network Retail/Long-Term Care Pharmacy 31-day Supply (If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)	**Tier 1: Generic** — $10 **Tier 2: Preferred Brand** — $30 (after deductible) **Tier 3: Non-Preferred Drug** — $75 (after deductible for brand-name drugs) **Tier 4: Specialty (High Cost)** —After deductible, lesser of 8% of the cost **or** $450 for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days*	You can receive a 90-day supply at any CVS Pharmacy, Longs Drugs or Navarro Discount Pharmacy for the same price as mail service. Low-Cost Generic Drug Program medications are included.
Maximum Day Supply	**Retail:** 90 days (Medicare); 31 days (non-Medicare) **Mail Service:** 90 days (Medicare and non-Medicare)	
Mail Service Pharmacy Copayments/Coinsurance (If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)	**Low-Cost Generic Drug Program medications:** $9 **Tier 1: Generic** — $25 **Tier 2: Preferred Brand** — $75 (after deductible) **Tier 3: Non-Preferred Drug** — $187.50 (after deductible for brand-name drugs) **Tier 4: Specialty (High Cost)** — After deductible, lesser of 8% of the cost **or** $450 for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days*	
Maximum Out-of-Pocket Limit	If an enrollee pays a total of **$4,000** out of pocket in copayments/coinsurance/deductible for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.	

*Non-Medicare enrollees must use CVS Specialty pharmacy; Medicare enrollees may use any specialty pharmacy.

MEDICAL PLAN FEATURES FOR 2024

	Medicare				Non-Medicare	
	Aetna Medicare Plan (Medicare Advantage PPO)		**Aetna Basic Plan** (PPO or Indemnity)		**Aetna Basic Plan** (PPO or Indemnity)	
	In-Network (PPO) or Extended Service Area (ESA PPO)[1]	**Out-of-Network (PPO)[1]**	**In-Network and Indemnity[2,4]**	**Out-of-Network[2,4]**	**In-Network and Indemnity[2]**	**Out-of-Network[2]**
PLAN FEATURES						
Annual Deductible per Enrollee[3]	$0	$500	$2,500	$5,000	$2,500	$5,000
Out-of-Pocket Maximum[3] (Includes deductible, copayments and coinsurance. Excludes prescription costs.)	$1,500 per enrollee	$2,500 per enrollee	$6,500 per enrollee	$13,000 per enrollee	$6,500 per enrollee	$13,000 per enrollee
Lifetime Benefits Maximum per Enrollee	Unlimited		Unlimited		Unlimited	
Health Provider Access	Use network provider (PPO); use any provider that accepts Medicare and the Aetna plan (ESA PPO)	Use any provider that accepts Medicare	Use network provider (PPO); use any covered provider (indemnity)	Use any covered provider	Use network provider (PPO); use any covered provider (indemnity)	Use any covered provider
PHYSICIAN, HOSPITAL, SKILLED NURSING AND HOME HEALTH CARE						
Primary Care Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays $0 (no deductible)	Enrollee pays $40 after deductible	Enrollee pays $20 (no deductible)	Enrollee pays 50% after deductible	Enrollee pays $20 (no deductible)	Enrollee pays 50% after deductible
Specialist Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays $25 (no deductible)	Enrollee pays $55 after deductible	Enrollee pays 20%		Enrollee pays 20%	Enrollee pays 50%
Urgent Care	Enrollee pays $40 (no deductible)		Enrollee pays $40, then 20% after deductible		Enrollee pays $40, then 20% after deductible	
Hospital Services (Inpatient/Outpatient)	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20%[5]	Enrollee pays 50%[5]	Enrollee pays 20%	Enrollee pays 50%
Hospital Charges for Outpatient Surgery/Preadmission Testing	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20%		Enrollee pays 20%	Enrollee pays 50%
Emergency Room Care	Enrollee pays $75 (no deductible); copayment waived if admitted		Enrollee pays $150, then 20% after deductible; copayment waived if admitted		Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Skilled Nursing Facility (Benefit period varies by plan.)	Enrollee pays 0% after deductible; no day limit	Enrollee pays 8% after deductible; no day limit	Enrollee pays 20% (90 days per benefit period); after 90 days, enrollee pays 100%	Enrollee pays 50% (90 days per benefit period); after 90 days, enrollee pays 100%	Enrollee pays 20% (90 days per benefit period); after 90 days, enrollee pays 100%	Enrollee pays 50% (90 days per benefit period); after 90 days, enrollee pays 100%
Inpatient Mental Health	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20%; no limit on days	Enrollee pays 50%; no limit on days	Enrollee pays 20%; no limit on days	Enrollee pays 50%; no limit on days
Home Health Care	Enrollee pays 0% after deductible; no visit limit	Enrollee pays 8% after deductible; no visit limit	Enrollee pays 20%; no visit limit		Enrollee pays 20%; no visit limit	

[1] If providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for the excess charges.

[2] For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

[3] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate, except for the Aetna Medicare Plan.

[4] Benefits are payable after Medicare payments.

[5] Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

MEDICAL PLAN FEATURES FOR 2024

	Medicare				Non-Medicare	
	Aetna Medicare Plan (Medicare Advantage PPO)		**Aetna Basic Plan** (PPO or Indemnity)		**Aetna Basic Plan** (PPO or Indemnity)	
	In-Network (PPO) or Extended Service Area (ESA PPO)[1]	**Out-of-Network (PPO)[1]**	**In-Network and Indemnity[2,3]**	**Out-of-Network[2,3]**	**In-Network and Indemnity[2]**	**Out-of-Network[2]**
PREVENTIVE SERVICES (If you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, any applicable copayment/coinsurance/deductible will apply for care received for the existing medical condition.)						
Limited designated services such as routine physical, bone density screening, mammogram, colorectal screening, Pap smear and immunizations/inoculations; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations or Medicare guidelines when applicable. Contact the plan for details.	Enrollee pays 0% (no deductible)		Enrollee pays 0% (no deductible)		Enrollee pays 0% (no deductible)	
OUTPATIENT SERVICES						
Diagnostic X-ray/Lab Testing	Enrollee pays 4% for diagnostic X-ray after deductible; 0% for lab testing (no deductible)	Enrollee pays 8% for diagnostic X-ray after deductible; 0% for lab testing after deductible	Enrollee pays 20%		Enrollee pays 20%	
Outpatient Mental Health (Includes in-person, phone and video visits.)	Enrollee pays $25 (no deductible); no visit limit	Enrollee pays $55 after deductible; no visit limit	Enrollee pays 20%; no visit limit		Enrollee pays $20; no visit limit	
ADDITIONAL SERVICES (Contact the plan for details.)						
Fitness/Weight Management	SilverSneakers membership; discounts on weight management services		Discount membership to gyms in the GlobalFit network; discounts on weight management services		Discount membership to gyms in the GlobalFit network; discounts on weight management services	
Vision Care	Enrollee pays 0% for annual routine eye exam; eyewear discounts available at participating providers		Discounts on eye exams and eyewear		Discounts on eye exams and eyewear	
Hearing	Up to $1,000 reimbursement for hearing aids per 36 months; discount programs may also be available		Discount programs may be available		Discount programs may be available	
Telemedicine (Virtual provider visits; provider varies by plan.)	Enrollee pays $0 for Teladoc visit (no deductible)	Teladoc visit covered at same level as in-network primary care physician or specialist physician office visit	Teladoc visit covered at same level as in-network primary care physician or specialist physician office visit		Teladoc visit covered at same level as in-network primary care physician or specialist physician office visit	
Non-Emergency Transportation (Transportation for non-emergency medical appointments.)	Enrollee pays 0%; trip and mileage allowances may apply; unlimited transportation for dialysis patients		No coverage		No coverage	

[1]If providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for the excess charges.

[2]For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

[3]Benefits are payable after Medicare payments.

MONTHLY PREMIUMS FOR 2024

ELIGIBILITY GROUP* (See requirements below)		Medicare		Non-Medicare
		Aetna Medicare Plan (Medicare Advantage PPO)	**Aetna Basic Plan** (PPO or Indemnity)	**Aetna Basic Plan** (PPO or Indemnity)
BENEFIT RECIPIENT ELIGIBLE FOR SUBSIDY YEARS OF SERVICE		**MONTHLY PREMIUM**	**MONTHLY PREMIUM**	**MONTHLY PREMIUM**
Retired before 8/1/2023	**Retire on or after 8/1/2023**	Premiums shown below are reduced by a $30 Medicare Part B credit for benefit recipients enrolled in an STRS Ohio Medicare plan. Enrollment in Medicare Part B is mandatory.		Medicare Part B credit does not apply.
30+	35+	25	137	279
29	34	28	140	307
28	33	32	144	335
27	32	35	147	363
26	31	39	151	391
25	30	42	154	419
24	29	46	158	447
23	28	50	162	475
22	27	53	165	503
21	26	57	169	531
20	25	60	172	558
19	24	64	176	586
18	23	67	179	614
17	22	71	183	642
16	21	74	186	670
15	20	78	190	698
Benefit Recipient Not Eligible for Subsidy		131	243	1,117
Benefit recipients enrolled in the Health Care Assistance Program pay a $0 monthly premium. Eligible dependents pay premiums shown below.				
Spouse		161	273	1,117
Per Child		161	273	296
Disabled Adult Child		161	273	1,117

***Eligibility Requirements**

- **Retire on or after Aug. 1, 2023:** At least 20 years of service credit is required to qualify for coverage and a subsidy.
- **Retired Jan. 1, 2004–July 1, 2023:** At least 15 years of service credit is required to qualify for coverage and a subsidy.
- **Retired before Jan. 1, 2004:** No minimum years of service credit is required to qualify for coverage; however, at least 15 years of service credit is required to qualify for a subsidy.