Get ready for 2024

Before the new plan year starts, it's important to review the benefits of your The Federal Employees Health Benefits Program plan.

Our existing contract with Medicare is changing which will require new ID cards. Please see below for benefit enhancements. You won't need to take any action to remain covered by your Aetna Medicare Advantage Plan in 2024.

Look for your new member ID card
You can start using it January 1, 2024. (Be sure to share it with your doctor, hospital and pharmacy, too.) Until then, keep using your current member ID card.

What do I need to know as a member of the Aetna Medicare Advantage Plan?
This mailing includes important information about this plan and the coverage it offers. Please review this information carefully. You may also want to review your Summary of Benefits document and your 2024 Evidence of Coverage documents, which are available by calling Aetna® Member Services at **1-866-241-0262 (TTY: 711)**, Monday–Friday, 8 AM–8 PM ET or visiting AetnaFeds.com/advantage.

Your Evidence of Coverage will help you to understand which rules you must follow to get coverage with this Medicare Advantage plan. To remain enrolled in this Medicare health plan, you don't have to do anything, and your enrollment for 2024 will automatically begin on January 1, 2024.

As a member of the Aetna Medicare Plan, you have the right to appeal plan decisions about payment or services if you disagree.

You can be in only one Medicare Advantage plan at a time.

By participating in this Medicare health plan, you acknowledge that the Medicare health plan will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that the Medicare health plan will release your information including your prescription drug purchase history to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

We are enrolling you in your Aetna Medicare Advantage Plan as your retiree health benefit plan beginning January 1, 2024, unless you tell us by December 31, 2023 that you don't want to be in this plan. You will be automatically enrolled into this plan for 2024, and this enrollment will automatically cancel your enrollment in the 2023 Aetna Medicare Advantage Plan. Please call us at Aetna Member Services at **1-866-241-0262 (TTY: 711)**, Monday–Friday, 8 AM–8 PM ET if you think you should be enrolled in a different Medicare Advantage plan.

OMB Approval 0938-1051 (Expires: February 29, 2024)
GRP_ANOC_2024_N1_29748-4_32406-5_29749-1_32407-2
Master Plan ID: 0015113
The Federal Employees Health Benefits Program

What happens if I don't want to continue my Aetna Medicare Advantage Plan coverage in 2024?
You aren't required to be enrolled in this plan. You can decide to opt out of the Aetna Medicare Advantage Plan. To opt out, you may call Aetna Member Services at **1-866-241-0262 (TTY: 711)**, Monday–Friday, 8 AM–8 PM ET. Or you can call Medicare at **1-800-MEDICARE** anytime, 24 hours a day, 7 days a week for more information. TTY users should call **1-877-486-2048**. To request not to be enrolled by this process, please call Aetna Member Services at **1-866-241-0262 (TTY: 711)** , Monday–Friday, 8 AM–8 PM ET.

If you have questions about this letter or how to access your Summary of Benefits, please call Aetna Member Services at 1-866-241-0262 (TTY: 711), Monday–Friday, 8 AM–8 PM ET.

Thank you.

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 Federal Employees Health Benefits Program offered by Aetna Medicare

Annual Notice of Changes for 2024

You are currently enrolled as a member of The Federal Employees Health Benefits Program. Next year, there will be some changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage* and the *Schedule of Cost Sharing*, which is located on our website at AetnaFeds.com/Advantage. You may also call Member Services to ask us to mail you an *Evidence of Coverage* and/or *Schedule of Cost Sharing*.

What to do now

Determine: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review any medical benefit changes.
- Review drug formulary for any changes in drug coverage, including authorization requirements.
- Review any drug cost changes.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible sin cargo en español.
- Please contact our Member Services at the telephone number on your member ID card or call our general Member Services at 1-866-241-0262 for additional information. (TTY users should call 711.) Hours are 8 AM to 8 PM ET, Monday through Friday. This call is free.
- This document may be available in other formats such as braille, large print or other alternate formats. Please contact Member Services for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About The Federal Employees Health Benefits Program

- Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.
- When this document says "we," "us," or "our," it means Aetna Medicare. When it says "plan" or "our plan," it means The Federal Employees Health Benefits Program.

Y0001_ANOC24_M

OMB Approval 0938-1051 (Expires: February 29, 2024)

Annual Notice of Changes for 2024
Table of Contents

OMB Approval 0938-1051 (Expires: February 29, 2024)

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for The Federal Employees Health Benefits Program in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
Deductible	**No Deductible**	**No Deductible**
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network and out-of-network providers combined: **$0**	From network and out-of-network providers combined: **$0**
Doctor office visits	Primary care visits: **$0** copay per visit. Specialist visits: **$0** copay per visit.	Primary care visits: **$0** copay per visit. Specialist visits: **$0** copay per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**$0 per stay**	**$0 per stay**

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.) You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	**Deductible:** No Deductible **Standard cost-sharing** (30-day supply) during the Initial Coverage Stage: *Preferred Generic:* You pay $2 *Generic:* You pay $10 *Preferred Brand:* You pay $40 *Non-Preferred Brand:* You pay $75 *Specialty:* You pay 25%, but not more than $350, for your drug **Catastrophic Coverage:** • During this payment stage, the plan pays the full cost for your covered Part D drugs. • For each covered Part D prescription drug, you pay nothing.	**Deductible:** No Deductible **Standard cost-sharing** (30-day supply) during the Initial Coverage Stage: *Preferred Generic:* You pay $2 *Generic:* You pay $10 *Preferred Brand:* You pay $40 *Non-Preferred Brand:* You pay $75 *Specialty:* You pay 25%, but not more than $350, for your drug **Catastrophic Coverage:** • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our non-Part D supplemental benefit.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Your coverage is provided through FEHBP. Refer to the Official Plan Brochure for the FEHBP premiums.

Cost	2023 (this year)	2024 (next year)
Part B premium reduction	$100 per month	$100 per month

You must also continue to pay your Medicare Part B premium.

- You may also be required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- You may qualify for extra help with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket during the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles, if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) and costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$0**	**$0** Once you have paid $0 out-of-pocket for covered services, you will pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at AetnaFeds.com/Advantage. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a *Provider and/or Pharmacy Directory*, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the *2024 Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the *2024 Pharmacy Directory* to see if your pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Continuous Glucose Monitors	Continuous Glucose Monitors can be obtained at participating DME providers.	You can get a Dexcom or FreeStyle Libre brand continuous glucose monitor and supplies at a participating pharmacy location or participating DME provider. If you choose any other brand, you can only use a participating DME provider. You will need a prescription to get your monitor and supplies.
Emergency transportation (worldwide)	Emergency transportation services (worldwide) are not covered.	You pay a $0 copay for each service. Cost sharing is not waived if you are admitted to the hospital.
Meals (post-discharge)	You pay a $0 copay for up to 14 home-delivered meals over a 7-day period following an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility stay. Meals are delivered by GA Foods.	You pay a $0 copay for up to 14 home-delivered meals over a 7-day period following an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility stay. Meals are delivered by NationsMarket.
Over-the-Counter (OTC) items	Over-the-counter items are not covered.	$30 quarterly allowance for over-the counter (OTC) medications and supplies. This benefit includes certain nicotine replacement therapies.

Section 1.5 Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. You can find the formulary name in the *2024 Prescription Drug Schedule of Cost Sharing*.

We made changes to our "Drug List", which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30th, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage
Your cost sharing in the initial coverage stage may be changing from a copayment to coinsurance *or* coinsurance to a copayment. Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in the *2024 Prescription Drug Schedule of Cost Sharing* included in this packet. We changed the tier for some of the drugs on our "Drug List". To see if your drugs will be in a different tier, look them up on the "Drug List". You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** *Preferred Generic:* You pay $2 *Generic:* You pay $10 *Preferred Brand:* You pay $40 *Non-Preferred Brand:* You pay $75 *Specialty:* You pay 25%, but not more than $350, for your drug	Your cost for a one-month supply filled at a network pharmacy: **Standard cost sharing** *Preferred Generic:* You pay $2 *Generic:* You pay $10 *Preferred Brand:* You pay $40 *Non-Preferred Brand:* You pay $75 *Specialty:* You pay 25%, but not more than $350, for your drug
	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages
The other two drug coverage stages — the Coverage Gap Stage and the Catastrophic Coverage Stage — are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D

drugs. You may have cost sharing for excluded drugs that are covered under our non-Part D supplemental benefit.

For specific information about your costs in these stages, look at your *2024 Prescription Drug Schedule of Cost Sharing*.

The Federal Employees Health Benefits Program Annual Maximum Out-of-Pocket (MOOP)

Maximum Out-of-Pocket (MOOP) — The most a person will pay in a year for deductibles and copayments/coinsurance for covered prescription drug benefits. After you reach your individual maximum out-of-pocket costs of $2,000, The Federal Employees Health Benefits Program will pay the rest of your annual drug costs.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Contract change	Your plan for 2023 is on CMS contract H5521.	Your plan for 2024 will be on CMS contract H5522.

SECTION 3 Deciding Which Plan to Choose

Section 3.1	If you want to stay in The Federal Employees Health Benefits Program

You don't need to do anything to stay enrolled in your Aetna Medicare Plan.

Section 3.2	If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can opt back into your FEHBP.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Aetna Medicare Plan (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from The Federal Employees Health Benefits Program.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information

on how to do so.
- – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

You are able to disenroll from FEHBPs MAPD at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIP at the phone number in **Addendum A** at the back of the *Evidence of Coverage*.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- ***"Extra Help" from Medicare.*** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Many states have a program called the State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in **Addendum A** at the back of the *Evidence of Coverage*).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP for your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP for your state (the name and phone numbers for this organization are in the **Addendum A** at the back of the *Evidence of Coverage*).

SECTION 7 Questions?

Section 7.1 Getting Help from The Federal Employees Health Benefits Program

Questions? We're here to help. Please call Member Services at the telephone number on your member ID card or call our general Member Services at 1-866-241-0262. (TTY only, call 711.) We are available for phone calls 8 AM to 8 PM ET, Monday through Friday. Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)
This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* and the *Schedule of Cost Sharing* for The Federal Employees Health Benefits Program. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at AetnaFeds.com/Advantage. The *Schedule of Cost Sharing* lists the out-of-pocket cost share for your plan; a copy is included in this envelope. You can request a mailed copy of either of these materials directly from the website or by calling Member Services.

Visit our Website
You can also visit our website at AetnaFeds.com/Advantage. 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").

Section 7.2 Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)
You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website
You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*
Read the *Medicare & You 2024* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

See the *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 Aetna 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.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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.

OMB Approval 0938-1051 (Expires: February 29, 2024)

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

繁體中文 (CHINESE): 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。

OMB Approval 0938-1051 (Expires: February 29, 2024)

How we guard your privacy

What personal information is — and what it isn't
By "personal information," we mean information that can be used to identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.
How we get information about you
We get information about you from many sources, including you. We also get information from your employer, other insurers, or health care providers like doctors.
When information is wrong
Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.
How we use this information
When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your OK when we do. We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work. This means we may share your information with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.
When we need your permission
There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices, which took effect October 10, 2020. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, just visit our member website or call the toll-free number on your ID card.

Form Approved
OMB#0938-1421

Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-241-0262. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-241-0262. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-241-0262。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-241-0262。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-241-0262. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-241-0262. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-241-0262. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-241-0262. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-241-0262. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-241-0262. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-241-0262 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-241-0262. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-241-0262. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-241-0262. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-241-0262. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-241-0262. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-241-0262. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hawaiian: He kōkua māhele ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-866-241-0262. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

Y0001_NR_30475b_2023_C

Form CMS-10802
(Expires 12/31/25)

The Federal Employees Health Benefits Program Member Services

Method	Member Services – Contact Information
CALL 	The number on your member ID card or 1-866-241-0262. Calls to this number are free. Hours of operation are 8 AM to 8 PM ET, Monday through Friday. Member Services also has free language interpreter services available for non-English speakers.
TTY 	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM ET, Monday through Friday.
WRITE 	Aetna Medicare PO Box 7082 London, KY 40742
WEBSITE 	AetnaFeds.com/Advantage