March 2026

OfficeLink Updates™

Welcome to the latest edition of OfficeLink Updates (OLU). As always, we provide you with relevant news for your office.

HIGHLIGHTS IN THIS ISSUE

Get secure access to patient health information

You can retrieve clinical and claims encounter data for Aetna-covered patients through our Application Programming Interface (API). The API consolidates information to help you coordinate care.

How to request PAs on Availity

We review tips from our last issue and summarize new ones, such as how to add frequently used providers to drop-down lists. We also cover what not to do so that your PA is approved as quickly as possible.

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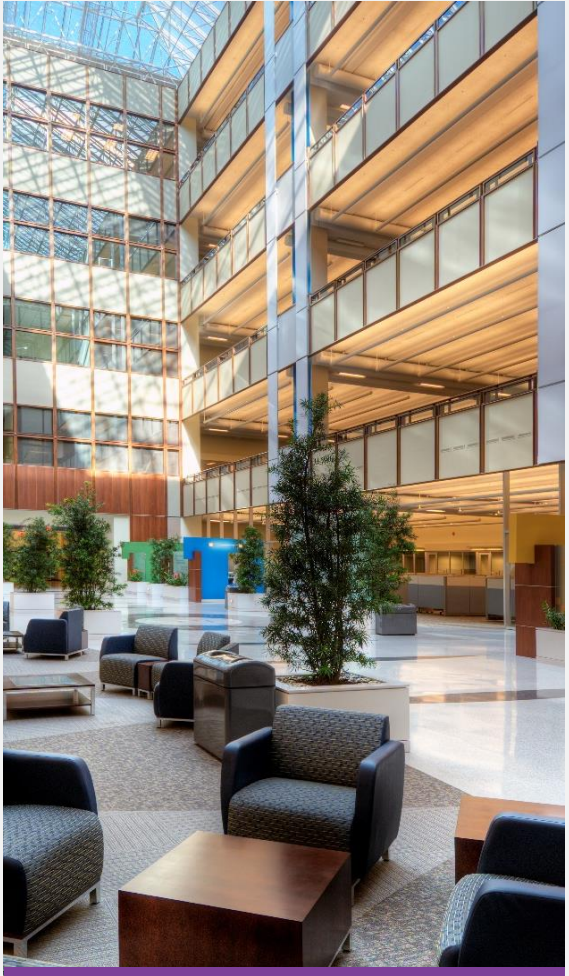

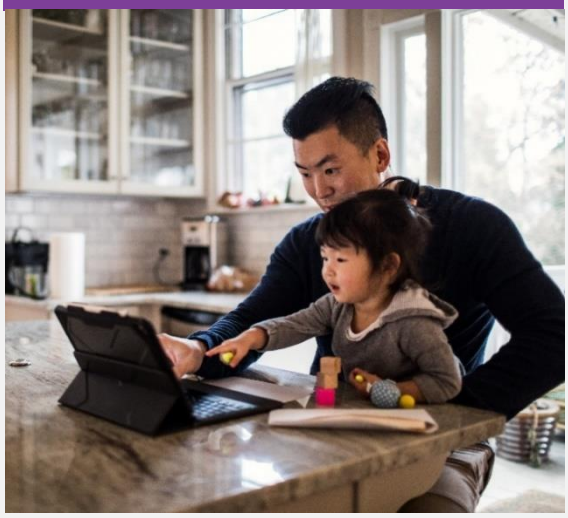

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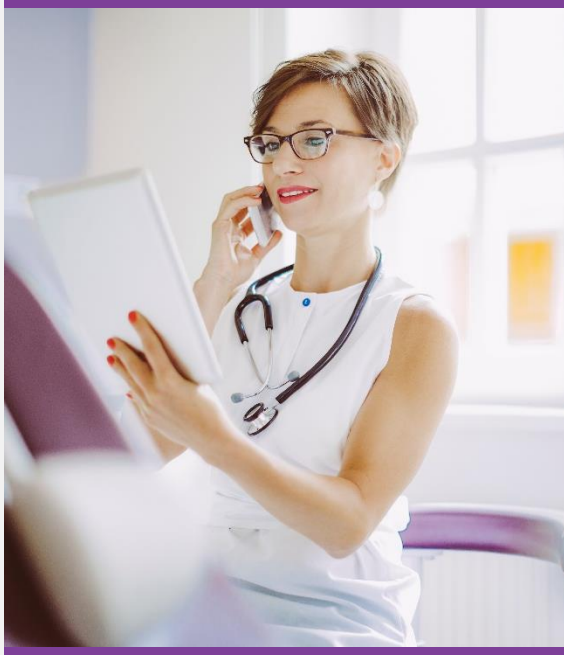

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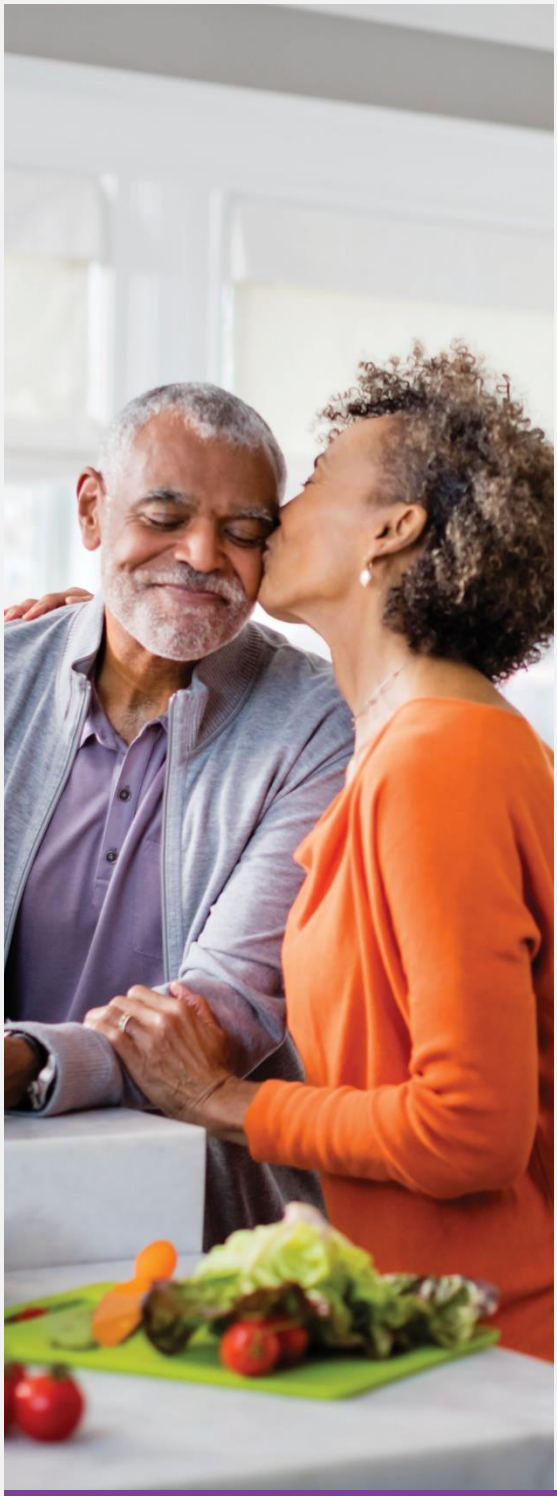

Important policy updates (including pharmacy)

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment.

We're required to notify you of any change that could affect you either financially or administratively. These changes may not be considered material changes in all states.

Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Claim and Code Review Program (CCRP) update

Starting June 1, you may see new claim edits.

This update applies to our commercial, Medicare, and Student Health members.

Our program evaluates claims against industry coding guidelines such as those from the Centers for Medicare & Medicaid Services (CMS), American Medical Association Current Procedural Terminology (CPT®) coding standards, and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.*

Beginning June 1, 2026, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **provider portal on Availity**.**

For coding changes, go to Aetna Payer Spaces > Resources. In the search bar, search for "expanded claim edits."

Except for Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to Availity®. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims, and bundled services claims, to help confirm coding accuracy.

**Availity® is available only to providers in the U.S. and its territories.

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be outlined in this article.

Note to Maine providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Treatment room services policy change

We're updating our original treatment room services policy, which became effective on April 1, 2021.

Starting June 1, 2026, we'll no longer separately pay for treatment room services (revenue codes 760/761 and now, 769) when billed with the following:

- Inpatient stay
- Outpatient minor surgical or medical procedure
- Outpatient observation stay
- Emergency room visit
- Urgent care visit
- Laboratory and/or radiology services

Also as of June 1, we'll exclude payment for Evaluation and Management (E&M) services when billed with revenue codes 760/761/769.

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes

required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

State-specific updates

Here you'll find state-specific updates on programs, products, services, policies and regulations.

Aetna® Medicare offers chiropractic care through WholeHealth Living®

Find out whether you participate in the D-SNP plans.

This article applies to Alabama, Arkansas, Louisiana and Mississippi.

All D-SNP plans in Alabama, Arkansas, Louisiana and Mississippi offer a supplemental chiropractic benefit through WholeHealth Living®, an NCQA-CVO-accredited company. This benefit does not require any referrals and includes twelve in-network annual visits with a $0 copay.

In addition to chiropractic services offered for HMO D-SNP plans, chiropractic services are also offered on PPO D-SNP plans for all states listed above. In addition, PPO D-SNP plan members have an "out-of-network" benefit, which means they can see a practitioner outside the WholeHealth network.

You can find out whether you participate in the D-SNP plans by visiting the **Aetna Medicare directory**.

For more information, refer to the **Contact Aetna** page.

Reminder: VCC form required for Aetna® Medicare C-SNP enrollment

The Verification of Chronic Condition (VCC) form continues to be a required step in the C-SNP enrollment process.

This article applies to the following states: Arizona, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Michigan, Minnesota, Missouri, Nevada, New York, North Carolina, Ohio, Pennsylvania, South Carolina and Texas.

Our Chronic Special Needs Plans (C-SNPs) help eligible members with diabetes, congestive heart failure (CHF) and/or cardiovascular disorders better manage their conditions and improve overall health.

In 2026, C-SNPs will expand into additional counties across several states. The VCC requirement applies in all counties where C-SNPs are offered, including:

- Currently participating counties in Illinois and Pennsylvania
- Newly added counties in the following states beginning January 2026: Arizona, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Michigan, Minnesota, Missouri, Nevada, New York, North Carolina, Ohio, Pennsylvania, South Carolina and Texas

C-SNP enrollment is a two-step process

Step 1: Enrollee completes a Medicare Pre-Qualification Assessment Tool (PQAT) form as part of the enrollment application.

Enrollees must complete a PQAT form that includes their qualifying diagnosis and contact information for at least one provider who can verify the member's chronic condition.

Step 2: Providers complete the VCC form within the first 30 days of enrollment.

We send the VCC form to the provider (PCP or specialist) listed on the application via fax and/or email based on the contact information the member submitted on the PQAT form. If an email address is provided, the provider will also receive an email with an access code to attest to the member's qualifying condition electronically via their Availity® account.*

If we don't receive the completed VCC form confirming the member's qualifying condition by the end of the second month post enrollment, the member will be involuntarily disenrolled from the C-SNP plan.

How to access and submit the VCC form

You can complete and submit the form using one of the following methods:

- Our **provider portal on Availity**. Go to Aetna Payer Spaces > Resources. In the search bar0 search for "VCC."
- Our **Forms for Health Care Professionals page**. Select "Chronic Condition Special Needs Plans (C-SNPs)/ Enrollment Verification" from the drop-down menu.
- Going directly to the **VCC form (PDF)**. You'll find submission instructions at the bottom of the form.

*Availity® is available only to providers in the U.S. and its territories.

Material amendment/change to contract

This article applies to the following states: Colorado and Ohio.

For important information that may affect your payment, compensation or administrative procedures, refer to the **Important Policy Updates** section of this newsletter.

Aetna® Market Fee Schedule (AMFS) update

This article applies to the following states: Iowa and Nebraska

We're updating our AMFS for plans in your service area. The changes, which start on July 15, 2026, affect the services we pay you for based on AMFS. You can find these services in the compensation section of your contract.

How we determine our fee schedule

We look at industry standards and other sources, such as the Resource-Based Relative Value Scale (RBRVS) on the Centers for Medicare & Medicaid Services (CMS) website.

- For codes using RBRVS, we use the site-of-service differential. This lets us make additional payments for certain codes based on the service location.
- For codes where RBRVS is either not used or not available, we use sources like external vendor pricing models, Medicare fee schedules and nationally contracted rates.

View the fee schedule

You can view the fee schedule on **our provider portal on Availity**.* Or go to **Aetna.com**. Choose "more Aetna" then "medical providers." Then choose "claims."

We're here to help

If you have questions, call us at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)**.

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Aetna® Market Fee Schedule (AMFS) update

This article applies to the state of Kansas, including the Kansas City, Missouri, area.

We're updating our AMFS for plans in your service area. The changes, which start on July 15, 2026, affect the services we pay you for based on AMFS. You can find these services in the compensation section of your contract.

How we determine our fee schedule

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We're here to help

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Maine: Review CPBs and pain management protocols

We encourage you to regularly review Clinical Policy Bulletins (CPBs) and related pain management programs. Visit our **Medical Clinical Policy Bulletins** page to access CPBs and pain management protocols.

Missouri: Changes to the Aetna® Medicare Advantage (MA) home health program (Carelon) starting January 1, 2026

Starting January 1, 2026, Carelon will no longer manage the Aetna Medicare network for home health care services in the state of Missouri.

What to know

If your organization already has a direct contract on file with Aetna, you will continue to participate in the Aetna network. You will no longer need to submit Aetna Medicare claims to Carelon for payment. Starting January 1, 2026, submit Aetna Medicare claims directly to Aetna.

If your organization doesn't have a direct contract on file with Aetna, you will need to submit a request to our National Ancillary Team. Please **email a request** to continue participating in the Aetna network.You will no longer need to submit Aetna Medicare claims to Carelon for payment. Starting January 1, 2026, submit Aetna Medicare claims directly to Aetna.

You are required to follow Medicare guidelines related to home health care billing. For service dates beginning January 1, 2026, you will be responsible for billing the appropriate Notice of Admission (NOA) to Aetna.

Precertification

For Aetna Medicare members, precertification through Carelon is no longer required in the state of Missouri, effective January 1, 2026.

We're here to help

Thank you for being part of our network. If you have questions, contact Aetna Medicare at **1-855-335-1407 (TTY: 711)**, and choose option 4 for providers.

News for you

You'll find information — new services, tools and reminders — to help your office comply with regulations and administer plans.

New provider onboarding webinar for providers and their staff

Take our "Doing business with Aetna" webinar to get lots of your questions answered.

New to Aetna®? Or do you simply want to see what's new? Join us in our new provider onboarding webinar — **"**Doing business with Aetna" — to discover tools, processes and resources that'll make your day-to-day tasks with us simple and quick.

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related to eligibility, benefits, precertifications and claim status/disputes
- Locate Help & Training on Availity*
- Access our online forms
- Navigate to our provider referral directory and Medicare directory
- Update your provider data and much more

Register today

The **new provider onboarding webinar** — **"**Doing business with Aetna" — is offered on the second Tuesday and third Wednesday of the month from 1 PM to 2:30 PM ET.

Questions?

Just **email us** with any questions that you may have. We look forward to seeing you in an upcoming session.

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Help us promote antibiotic stewardship

Join us in supporting the Centers for Disease Control and Prevention (CDC) "Be Antibiotics Aware" initiative, which raises awareness about safe and appropriate antibiotic use.

How you can help

Prescribe antibiotics only when they are clinically indicated. Talk to your patients about possible harms from antibiotics. Explain to parents when children wouldn't benefit from taking antibiotics.

Patient resources

Help fight the overuse of antibiotics by educating your patients and staff. Many **CDC resources**, which include the following, are free:

- Handouts
- Trifold brochures
- Posters
- Infographics

- Sticker sheets, window and counter clings
- Videos and webinars
- Informational prescription pads

Our office manual keeps you informed

Refer to this manual for information about policies, utilization management (UM) decisions and medical record documentation.

Visit us online to view a copy of your **Office Manual for Health Care Professionals (PDF)**. The Aetna® office manual applies to the following joint ventures: Allina Health|Aetna and Banner|Aetna.

If you don't have Internet access, call our Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** to get a paper copy.

What's in the manual

The manual contains information on the following:

- Policies and procedures
- Our complex case management program and how to refer members
- Additional health management programs, including Healthy Aging Support, the Aetna Healthy Chapters, Lifestyle Condition Coaching and others
- Member rights and responsibilities
- How we make UM decisions, which are based on coverage and appropriateness of care and include our policy against financial compensation for denials of coverage
- Medical Record Criteria, which is a detailed list of elements we require to be documented in a patient's medical record and is available in the **Office Manual for Health Care Professionals (PDF)**

How to reach us

Contact us by visiting our **Contact Aetna** page, calling the Provider Contact Center at **1-888-MD AETNA (1-888-632-3862) (TTY: 711)** and selecting the "precertification" phone prompt, or calling patient management and precertification staff using the Member Services number on the member's ID card. The Medicare phone number is **1-800-624-0756 (TTY: 711)**. Our medical directors are available 24 hours a day for specific utilization management issues.

More information

Visit us online for information on how our quality management program can help you and your patients. We integrate quality management and metrics into all that we do, and we encourage you to take a look at the program goals.

Get secure access to patient health information

You can do this through your electronic health record (EHR) system starting in the second week of March.

Our new Provider Access Application Programming Interface (API) can reduce the need for faxes or supplemental documentation.

How the Provider Access API works

Using the API through your existing EHR workflow, you can retrieve specific clinical and claims encounter data for Aetna-covered patients with whom you have an active treatment relationship.

Through a standardized connection, the API consolidates information so you can better coordinate quality care by identifying and closing gaps.

The API does not replace direct clinical documentation, your EHR or your standard clinical workflows. Instead, it delivers additional, plan-level information that gives you a better view of a patient's care history.

What you can get from the API

The Provider Access API shares specific information that helps broaden the picture of a patient's health history and utilization, such as:

- Clinical information such as diagnoses, lab results and procedures
- Claims and encounter data that may not appear in a provider's native EHR
- Notes and other documentation to support care management, follow-up and gap-closure efforts

API requirements

We validate every request. You'll need to meet a few key requirements:

- Your EHR must be registered and subscribed to Aetna's Provider Access API.
- You must have a current treatment relationship with the patient connected to your request.

- You must be contracted with Aetna® or part of an in-network organization.
- Data access must be used solely for treatment, care coordination, and other permitted health care operations as defined under federal and state privacy rules.

These safeguards ensure that patient data is accessed responsibly and consistently, and only by those who are authorized.

Tips for working with Aetna® clinical teams

Read more on how to request prior authorizations (PAs) on Availity®.*

In our last issue (page 28), we offered PA submission tips when using our **provider portal on Availity**. Here, we'll expand on some of those and offer new ones.

Choose the appropriate admission type

In step 2 of the Authorization Add transaction on Availity, you can select one of the following admission types: Elective, Emergency or Urgent. Some of you select Urgent or Emergency to expedite our review when neither of those statuses apply to the patient's current condition. We abide by the Centers for Medicare and Medicaid Services (CMS) definition of time sensitive. It states that we must provide an expedited determination in cases where the time frame of the standard decision-making process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function.

We ask you to:

- Follow the same guidelines when choosing an admission type.
- Use the Provider Notes box at the bottom of step 2 to let us know why you're requesting an urgent or emergency authorization.

If you submitted your elective PA request on Availity and pinned the request to your Authorization/Referral Dashboard, we'll send regular updates as the request moves through our system.

Enter the correct name according to role

In step 3, we ask for the Attending and Admitting Providers and Facility. When we receive unexpected values in these fields, we must contact you to verify the correct names for each role. This may cause delays.

You can add frequently used providers to the Availity drop-down lists to ensure you're entering the correct value in each field. Here's how: from the Availity home page, under My Account Dashboard, select Manage My Organization > Manage Providers > Add

Provider(s). Enter and validate the requested information. After that, you'll find the providers in the drop-down lists without having to enter their NPIs manually.

Submit current clinicals

In step 4, you can upload clinicals to support your request. Reviewing records that aren't pertinent to the patient's current condition or are too old could delay our decision. We suggest not submitting medical records older than a year unless they help support your request. And please don't resubmit them through another means, such as by fax.

*Availity® is available only to providers in the U.S. and its territories.

Member access to care

Accessibility standards are available online.

We measure member access to care every year, in many ways. For example, we review:

- Member satisfaction survey results
- Complaint data
- Phone surveys we conduct (the phone surveys include a random sampling of primary care and specialty care providers)

Access standards include appointment availability time frames and after-hours care. Any state-established requirements can be found in the Provider Manual State Supplement.

Read more about the **access standards we measure**.

Thank you for taking part in these phone surveys. We do all this to comply with the National Committee for Quality Assurance (NCQA) accreditation standards and with various state regulations.

Affirmative statement for financial incentives

Here's how we make coverage decisions and help members access eligible services.

How we make coverage determinations and utilization management (UM) decisions

We use evidence-based clinical guidelines from nationally recognized authorities to make UM decisions.

- We review requests for coverage to see if members are eligible for certain benefits under their plan.

- The member, member's representative or a provider acting on the member's behalf may appeal this decision if we deny a coverage request.

How we help members access services

Our UM staff helps members access services covered by their benefits plans.

- We don't pay or reward practitioners or individuals for denying coverage or care.
- We base our decisions entirely on appropriateness of care and service and the existence of coverage.
- Our review staff focuses on the risks of underutilization and overutilization of services.

Questions?

Visit our **Contact Aetna** page to request hard copies of specific criteria, if needed.

Visit us online to view a copy of your **provider manual (PDF)**.

Medical clinical criteria

Find out how we make coverage decisions and where to go for more information.

How we determine coverage

Our licensed clinical staff use evidence-based clinical guidelines from nationally recognized authorities along with the terms of a member's benefits plan to guide utilization management (UM) decisions. When the initial clinical reviewer cannot approve a request, a medical director, pharmacist, dentist, or oral and maxillofacial surgeon reviews coverage requests and applies the appropriate clinical criteria or guidelines.

Our clinical staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition.

- **Guidelines for coverage determination**
- **MCGs** (Seattle, WA: MCG)
- **Aetna Clinical Policy Bulletins (CPBs)**
- **Centers for Medicare & Medicaid Services (CMS)**
    - National Coverage Determinations (NCDs) (under Coverage, then Medicare Coverage Database)
    - Local Coverages Determinations (LCDs) (under Coverage, then Coverage Determination Process)
    - Medicare Benefit Policy Manual (under Regulations & Guidance, then Manuals)

- **National Comprehensive Cancer Network (NCCN) guidelines**

We may use other recognized criteria or applicable state and federal guidelines, if needed. Note that the tools above do not replace the professional judgment exercised by properly trained, licensed and experienced clinicians and professionals who evaluate the provision of services in accordance with accepted standards of care.

We're here to help

Visit our **Contact Aetna** page to request hard copies of specific criteria, if needed.

Responsive care can help your practice

You can improve your relationship with your patients by taking simple steps, such as directing patients to interpretation services and registering for Continuing Medical Education (CME) courses.

Our commitment

To demonstrate our commitment to meeting all NCQA standards and ensuring that member access to care is available and satisfactory, each year we ask members about in-network providers' ability to meet their needs. We do this through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). We use the responses to monitor, track and improve members' experiences.

Language

Members with limited English proficiency have access to translation and interpretation services. Members also have access to TTY/TDD services for the hearing impaired.

Your Aetna® patients can access interpreter services by calling the number on the back of their ID card. There's no charge for this interpretation service.

Earn a Care Champion badge for your provider profile

We're committed to ensuring that everyone has a fair opportunity to be as healthy as possible.

Our **clinical educational hub** includes courses on topics to help improve member engagement and access. You can earn a digital Care Champion badge for your provider profile in three clinical areas of focus. Claim a badge after completing the free, on-demand, accredited courses and we'll add it to your profile. Aetna members will also see it in our provider directories.

Courses include:

- **Culturally Responsive Care**
- **LGBTQ+ Responsive Care**
- **Culturally Responsive PCP Behavioral Health Care**

To earn a badge, you'll need to:

1. Complete the Foundational Activity course
2. Complete a role-specific course
3. Complete the therapeutic-area-specific courses

Artificial Intelligence (AI) in Utilization Management (UM)

We may use AI to help review and process claims, including auto-approving claims that satisfy established UM criteria, and to support operational and service improvements. We never use AI to make adverse determinations based on medical necessity. Only licensed health care professionals issue medical necessity denials.

Behavioral health

Stay informed about behavioral health coverage updates so you can deliver the best possible treatment to your patients.

Care coordination contributes to better patient outcomes

We expect our behavioral health providers to work with medical providers, and this collaboration is both reimbursed and audited.

Many of your patients receive care from other behavioral health providers, primary care providers and medical specialists. The **Collaborative Care Model** is an evidence-based practice that leads to better patient outcomes.

Health Insurance Portability and Accountability Act (HIPAA) guidelines

Note the following **HIPAA guideline (PDF)** related to sharing behavioral health information: Health care providers may disclose Protected Health Information (PHI)(whether orally, on paper, by fax or electronically) for purposes of treatment, case management, coordination of care, payment, and health care operations without consent or authorization.*

Please request that patients sign release of information forms for all providers involved in their care. This will help ensure prompt communication between providers when necessary.

We expect collaborative care and reimburse for it

The CPT® codes for collaboration include 99484, 99492, 99493 and 99494.**

We evaluate our behavioral health providers on care collaboration via our annual Behavioral Health Practitioner Experience Survey and via treatment record audits. Please see the Coordination of Care section (page 35) of the current **Provider and Behavioral Health Manual** for more information.

Questions?

If you have any questions, please email the **Behavioral Health Quality Management team**.

*Covered entities must get patient authorization to disclose separately maintained psychotherapy session notes.

Helping patients with substance use disorders (SUDs)

As providers, you are in a unique position to identify SUDs and get your patients the care they need. According to the American Hospital Association, over 46 million Americans age 12 and older report struggling with substance use.[1] Remember: One conversation may be what leads to someone's recovery.

Knowledge is power

Research, treatments, and best practices are always evolving, and we work to stay updated in this ever-changing landscape. We encourage you to seek out continuing education regarding SUDs. Our **training resources** can help you understand and identify signs of SUD.

Screening can make a world of difference

Screening tools can help identify substance use and assist with a discussion about treatment options. We offer **screening tools, treatment options and support resources** for your patients.

Questions?

You can **send a message** to the Behavioral Health Quality Management team.

[1]American Hospital Association™ (AHA) News. **Survey: Most Americans with substance use disorders don't receive treatment**. Accessed December 11, 2025.

Medicare

Get Medicare-related information, reminders and guidelines.

Complete your required Medicare compliance training and attest by October 31, 2026

All participating providers in our Medicare Advantage (MA) plans must meet Centers for Medicare & Medicaid Services (CMS) compliance program requirements for First-Tier, Downstream, and Related Entities (FDRs). This includes completing the required trainings and submitting your annual attestation for MA plans, which include HMO, PPO and Special Needs Plans (SNPs).

In 2026, we'll send training and attestation notices to the compliance email(s) you provided on your 2025 attestation. If we don't have your compliance email address or if the email bounces, you'll receive a postcard reminder to complete your annual attestation (and Model of Care training, if applicable).

Our training materials

Training materials and attestations are posted on our **Medicare Resources and Support** page.

Trainings

- **FDR Medicare compliance guide (PDF)**
- **SNPs Model of Care (MOC) provider training (PDF)**
- **Provider and delegate frequently asked questions document (PDF)**

Attestations based on contracted plans

Providers:

- MA/MMP: **Complete MA and/or MMP attestation (PDF)**
- MA/SNP: **Complete MA and SNP attestation (PDF)**

Delegates:

- MA/MMP: **Complete MA/MMP attestation for first-tier entities (PDF)**
- MA/SNP: **Complete MA and/or SNP attestation for first-tier entities (PDF)**

Where to get more information

If you have questions, please choose from the above links or review the quarterly **First-Tier, Downstream, and Related Entities (FDR) compliance newsletters**.

EyeMed is the exclusive provider for Routine Vision benefits for Aetna® Medicare Advantage (MA) Individual plan members

Find out how to join the EyeMed network.

This article does not apply to the following:

- *Florida*
- *Select integrated D-SNPs, including the Aetna Medicare FIDE (HMO D-SNP) in Illinois, New Jersey, and Virginia and Aetna Medicare HIDE (HMO D-SNP) in Michigan*
- *Aetna Group MA plan members*

Effective January 1, 2026, Aetna MA Individual plan members must see an EyeMed provider for their routine vision benefits (exams and prescription eyewear) for those benefits to be considered in-network.

Always check eligibility

Some members have plans that provide only in-network benefits, while others have plans that provide both in- and out-of-network vision and eyewear coverage.

Remember to verify benefits and eligibility via Availity® or your preferred vendor or clearinghouse.*

HMOs and PPOs

Aetna MA Individual plan members (HMO/PPO) have access to the Aetna MA contracted network for Medicare-covered (medical/diagnostic) eye care services. Providers not contracted with EyeMed will only be reimbursed up to $50 for any routine (non-Medicare covered) eye exam services rendered for PPO members.

Consult the chart below for 2026 routine eye exam and eyewear benefits (non-Medicare covered).

Plan type	EyeMed provider	Non-EyeMed provider
HMO plan members	$0 copay for one non-Medicare covered routine eye exam.** $0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.	Not covered
PPO plan members	$0 copay for one non-Medicare covered routine eye exam.** $0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.	$0 copay for one non-Medicare covered routine eye exam up to $50.** Members are responsible for any billed amount over $50. $0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.

Verify whether you're an EyeMed provider

To verify, you can visit our **Vision Benefit page**. If you'd like to become an EyeMed provider, fill out this **EyeMed provider form**. Be sure to check the "Join EyeMed as New Provider" box.

*Availity® is available only to providers in the U.S. and its territories.

**If members receive additional services during the routine eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, they may also be responsible for the cost for the additional services received.

Aetna® HEDIS® data collection is underway

We'll be requesting timely access to members' medical records to monitor and compare health plan performance.

We'll be reaching out soon to collect medical record information on behalf of our members. We appreciate your understanding and cooperation as we complete this required quality reporting activity with minimal disruption to your practice.

Why is this necessary?

Healthcare Effectiveness Data and Information Set (HEDIS)* data collection is a nationwide, joint effort among employers, health plans and physicians. The goal is to monitor and compare health plan performance as defined by the National Committee for Quality Assurance (NCQA).

The Centers for Medicare & Medicaid Services (CMS) requires us to send health care quality data for our Aetna Medicare Advantage organizations. Most data are collected from claims and medical encounters. We also gather data from medical records.

What we may need from you

When we reach out to you, we will ask that you give us timely access to members' medical records. Our contracted representatives will collaborate with you and provide options for sending medical records.

Meeting HIPAA guidelines

Either our staff or a contracted representative will contact your office. Our contracted representatives, Ciox Health, Sharecare Inc., and MRO, serve as our Business Associates as defined under the Health Insurance Portability and Accountability Act (HIPAA).

Giving medical record information to a Covered Entity and to a Covered Entity's legally contracted Business Associate meets HIPAA regulations.

We appreciate your assistance in our medical record collection efforts.